North Carolina Department of Health and Human Services

BLUEPRINT FOR CHANGE

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

North Carolina's plan for mental health, developmental disabilities and substance abuse services

State Plan 2005

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Executive Summary

State Plan 2005: Blueprint for Change is the fifth annual update of the State Plan: Blueprint for Change series. This edition provides for the people of North Carolina the continuing efforts to transform North Carolina's public mental health, developmental disabilities and substance abuse services (mh/dd/sas) system. The mission, vision, guiding principles, philosophy and primary goals as stated in the initial State Plan remain the same.

In response to Session Law 2001-437, *State Plan 2001* established an understanding of reform including focusing the state's limited resources on those who are the most severely disabled. *State Plan 2002* outlined the key policy issues that set the direction for reform and *State Plan 2003* refined policy issues and set a course for developing some of the products and processes necessary to continue the momentum. *State Plan 2004* provided details on the key tasks and issues that needed to be addressed during state fiscal year 2004-2005. *State Plan 2005* highlights accomplishments of the last four years and elaborates the fundamental areas of person-centered planning, quality management, cultural competence and best practices. Further, it focuses on tasks that are necessary for the upcoming fiscal year to continue the process of system transformation.

Over the last four years, the Division and most stakeholders have realized that we are not just reforming the mh/dd/sas system; we are transforming it. This process requires much more than moving from one place to another by adding pieces. Transformation requires dismantling the old and creatively building the new. The process is challenging with periods of discouragement and periods of excitement. Many issues have been and will continue to be faced.

The People We Serve

Providing services to individuals with the most severe disabilities in communities of their choice is the primary focus of the re-designed mh/dd/sas system. As legislatively mandated, the Department of Health and Human Services established target populations that meet specified diagnostic and functional criteria plus circumstances unique to each individual. The target populations for adult mental health, child mental health, developmental disabilities and substance abuse have not changed from prior State Plans.

However, it is important to note that:

- Anyone can seek services through the public mh/dd/sa system. If the person is not a member of a target population, the system will provide screening and triage and refer the individual to private providers and other community organizations.
- Anyone who is eligible for Medicaid and meets "medical necessity" for covered mh/dd/sa services is entitled to those services, supports, treatment and/or care. If the person is not a member of a target population, the system will typically provide services that are less intensive and shorter in duration. If the person is a member of a target population, the system will usually provide services, supports, treatment and/or care that are more comprehensive, intensive and of longer duration.

- Anyone who is part of a target population can receive services through the public mh/dd/sa system. However, if not eligible for Medicaid, the provision of services is not an entitlement. Thus, the publicly sponsored system is challenged with managing available resources to meet the needs of these priority populations.

Organizational Structure of the Public MH/DD/SAS System

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) remains actively involved in reform. The members of this committee meet regularly with leadership of the Department of Health and Human Services (DHHS), its Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the public to receive input on the status of the reform efforts. The Division provides quarterly reports to the LOC on matters related to implementation.

The North Carolina Commission for MH/DD/SAS, a rulemaking body created by the General Assembly, advises the Secretary of DHHS about the need for and the provision and coordination of services. The Commission has authority to make rules based on statutes regarding operations of local mh/dd/sa program operation and state facilities, licensing of mh/dd/sa facilities, controlled substances, clients' rights, human rights committees and mh/dd/sa services for people in the custody of the Department of Correction.

The Division of MH/DD/SAS completed its reorganization in 2003 to implement the State Plan and promote and accommodate the transformed system statewide. The Division's central administration consists of the Director's Office and five sections organized along functional lines. The organizational units are:

- Division Director's Office – The Division Director's Office provides strategic and operational leadership and oversight for the public MH/DD/SAS system. The Office includes the positions of Division Director, Deputy Division Director and the Chief of Clinical Policy.

- State Operated Services – This section holds a dual role as manager and provider of state operated services and facilities and is held to the same quality and best practice standards as are local management entities (LMEs). The Division's state facilities consist of four regional psychiatric hospitals, four developmental centers, three substance abuse treatment centers, a specialty nursing facility for mentally ill consumers, a specialty nursing facility for consumers with developmental disabilities and two residential facilities for children with emotional disturbances.

- Community Policy Management – This section is responsible for leadership, guidance and oversight of the community based service delivery system. The section performs the functions of the single state agency (SSA) for substance abuse and of the state methadone authority. It is organized into the following teams: the Quality Management Team, the Best Practice and Community Innovations Team, the Local Managing Entity Systems Performance Team, the Justice Systems Innovations Team and the Prevention and Early Intervention Team. The Employee Assistance Program is also a part of this section.

- Advocacy and Customer Service – This section leads the Division's efforts to create a community where people with disabilities are valued and treated with dignity and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. The State Facilities Advocates Team ensures the rights of consumers at state facilities. The Customer Service and Community Rights System Team ensures the rights of consumers served in the community, oversees response to complaints and monitors community customer services. The Consumer Empowerment Team ensures a consumer and advocacy voice in Division reform efforts and provides technical assistance to local consumer and family advisory committees (CFACs), to local consumer controlled advocacy organizations and to self-advocacy initiatives.

- Resource/Regulatory Management – This section is responsible for supporting the efforts and ensuring accountability of the operations of other sections of the Division. This is accomplished through the work of the following teams. The Budget and Finance Team is responsible for the budget and finance strategies, and planning and management. The Information Systems Team is responsible for systems management, development and business automation, coordination and technical support to end users. The Accountability Team is responsible for ensuring Medicaid and overall fiscal integrity within the Division including state operated services and the community system and for ensuring compliance by the Division for Medicaid development, substance abuse issues, PASARR pre-admission screening and annual resident reviews, ICF-MR level of care determinations, provider enrollment and regulatory interpretations. The Contract Management Team is responsible for negotiating, managing, monitoring and reporting performance-based contracts and agreements as well as managing property, inventories and purchasing.

- Operations Support – This section is responsible for providing support and ensuring coordination with DHHS for all other sections of the Division. This section is composed of three teams: the Planning Team, the Division Affairs Team and the Communications and Training Team. The Planning Team is responsible for strategic planning, planning support, project management and resource development. Communications and Training Team is responsible for public communications, internal and stakeholder systems communications, academic systems liaison, human resources management, and all tasks related to internal and external training. The Division Affairs Team is responsible for rulemaking, legislative liaison functions, client appeals, and support for the NC Commission for MH/DD/SAS.

Community based mental health, developmental disabilities and substance abuse services are provided through a network of area authorities or county programs[1] that cover the state's 100 counties. These programs are in the process of making the transition from providing mh/dd/sa services to becoming local management entities (LMEs) that oversee and manage local services. Of the 33 programs, 29 have been certified by the Secretary of DHHS as LMEs. Whether governed by an area authority board appointed by boards of county commissioners or under the management of the county, LMEs are responsible for planning, budgeting,

[1] General Statute 122C-3 defines "area authority" as the area mental health, developmental disabilities and substance abuse authority. A "county program" means a mental health, developmental disabilities, and substance abuse services program established, operated and governed by a county pursuant to G.S. 122C-115.1.

implementing and monitoring community based mental health, developmental disabilities and substance abuse services. In managing services, the LMEs are expected to perform a series of functions not previously expected of area programs, including (1) access to services on a 24/7/365 basis; (2) building mechanisms to ensure greater consumer input into the management of the service delivery system; (3) coordinating with other public and private agencies to identify the consumer base and gaps in services; (4) recruiting providers and contracting with qualified providers, and (5) approving the person-centered plans for individual consumers.

State Plan 2001 directed each LME to create a Consumer and Family Advisory Committee (CFAC) composed of individuals who are consumers or family members of consumers of each of the major disability groups. The local CFAC advises the LME on all aspects of the local system development and operation. A state-level CFAC has been established to inform the Secretary of DHHS on issues and concerns about the development and operations of the overall mh/dd/sas system.

Transformation of the NC MH/DD/SA Services System

Over the past four years, the Division has continued to develop the infrastructure needed to transform the community system, the participation of consumer and families in reform, state facilities, child services, the partnership with the justice system, community education and the workforce, and information technology and services.

Transformation of the Community System

During state fiscal year 2004-2005, the Department of Health and Human Services (DHHS), the N.C. Council of Community Programs (NCCCP), and the N.C. Association of County Commissioners (NCACC) negotiated a statewide performance contract between DHHS and LMEs. The contract continues to evolve as LMEs transition to full local managers of service and public policy through new performance expectations and measures.

House Bill 381 requires the Secretary of DHHS to develop a catchment area consolidation plan of no more than 20 area authorities/county programs. The completed consolidation plan was submitted in February 2005 to the Joint Legislative Oversight Committee on MH/DD/SAS, the Governor and each board of county commissioners. In recognition of the significant changes taking place in the system and the right of a county to manage it own program, DHHS does not believe it is possible or prudent to force consolidation of programs that do not choose to merge voluntarily. There are issues other than population or geographic size that can affect the ability of a program to fulfill its obligations as an LME. DHHS recommended that over time the right sizing of the community system will occur without need to force consolidations.

In March 2005, the Division published Communication Bulletin #35 that provides guidance on the development of community-based crisis stabilization services and clarifies the relationship of local crisis services to an LME's responsibility for access/screening/triage/referral. A flowchart illustrates the process. By clarifying expectations about the provision of local crisis services, the

Division also addressed the expected role of state operated facilities as a safety net for brief hospital or crisis unit stays.

Key strategies for building community capacity include transferring funding to communities as a result of downsizing of state operated facilities and ensuring decent, safe and affordable housing for persons with mental illness, developmental disabilities and/or substance abuse disorders. Housing is directly related to a community system's ability to provide the depth and range of services needed. LMEs must assure that housing needs are included through their administrative structures or through contracts with housing resource develop organizations to develop a range of housing/residential capacity within the geographic area.

Service definitions and rates are a crucial requirement of developing local capacity and continue to be a major focus of transformation. This includes the development of the revised comprehensive CAP-MR/DD waiver and the self-directed services waiver that promote the ability of individuals to live in communities of their choice, lift fiscal limits, and provide natural and flexible supports for the individual. These have been submitted to the federal Centers for Medicare and Medicaid Services (CMS) for approval.

The enhanced benefit service definition package is for persons with complicated service needs. Initial treatment or service occurs at the time a diagnostic assessment is ordered and the person-centered planning begins. Changes that are reflected in the new or modified service definitions currently under review by CMS reflect evidence based best practices and emerging or promising practices. All services include utilization review guidelines and requirements for staff, training, accreditation and response to consumer crises. There are new services for children and adults and expanded services for substance abuse treatment.

The Division is committed to supporting and serving citizens through changes in the service definitions that reflect models of best practice and provider qualifications. **It is very important for LMEs, consumers and families and citizens to understand that services provided directly by the LMEs will not be discontinued until the local area has adequate providers in place to provide the services needed so that consumers' treatment and supports are not disrupted.**

Transformation of Consumer and Family Participation in Reform

The Secretary of DHHS appointed twenty-one consumers and family members to membership on the State Consumer and Family Advisory Committee (SCFAC). The committee has established foundation documents, a communication protocol and priorities for the upcoming year. With the assistance of the Division's Advocacy and Customer Service section, the SCFAC is developing a resource manual for local CFACs including sample bylaws, methods of merging, newsletters and means of successful partnering with LMEs.

The Division's Advocacy and Customer Service section is instrumental in the Department's commitment to customer service by training Division staff; responding to customer complaints, requests for information and Medicaid recipients' appeals regarding services; and providing technical assistance to LMEs as they develop customer service offices. Local offices are responsible for promoting public information about services and rights, supporting local CFACs

and human rights committees and conducting rights investigations. The Division's Advocacy and Customer Service section also provides advocacy services to consumers who receive care and treatment in state operated facilities. Advocacy includes training of consumers, family members and facility staff and conducting rights investigations.

Transformation of State Facilities

DHHS has committed to the construction of a new regional psychiatric hospital in Butner, N.C. The 432 bed facility will service persons who need inpatient psychiatric services in both the north and south central regions of the state. Dorothea Dix Hospital in Raleigh and John Umstead Hospital in Butner continue to provide services and will continue to downsize until remaining patients and admissions can be accommodated in the new facility. Construction is expected to be completed by late summer of 2007.

The Division is transforming the alcohol and drug abuse treatment centers (ADATCs) to increase acute capacity and divert involuntary substance abuse commitments from the state psychiatric hospitals. ADATCs will provide medically monitored detoxification, crisis stabilization and short-term treatment to prepare adults with substance abuse problems for ongoing community-based recovery services. Strategic planning is in process with the ADATCs to introduce evidence based treatment models and protocols for individuals who are unable to stabilize and initiate treatment in the community.

Efforts continue to downsize the four state operated psychiatric hospitals and distribute trust fund monies to community programs. The Division has worked with LMEs on a multi-year bed day allocation plan that accounts for beds closed by downsizing. A three-year pilot is examining the need for and effectiveness of a specialized rate structure to support psychiatric patients in community skilled nursing facilities. The North Carolina Special Care Center (NCSCC) has undergone renovations to open an additional 20 bed unit and further renovations can allow expansion of up to 47 beds for skilled nursing care.

The Division's developmental centers continue to downsize by working closely with consumers who are interested in receiving community services, their families, LMEs and providers. Sixty-four providers responded to a request for information indicating their interest in providing life-long, person-centered services and supports for consumers moving from developmental centers to communities.

Transformational Activities

The Division has been involved in a number of other activities that contribute to the transformation of the mh/dd/sas system. These include:

- Implementation of the Child Mental Health Plan (September 2003).
- A public/private partnership to develop bipartisan recommendations to improve the likelihood that adults released from prison or jail will become productive, healthy members of families and communities.
- Enhancement of justice system innovations through Treatment Accountability for Safer Communities (TASC), driving while impaired services (DWI), drug education school (DES),

jail diversion programs for persons with mental illness, Managing Access for Juvenile Offender Resources and Services (MAJORS), and the Drug Control Unit.

- Development of a strategic workforce development plan.
- Further development of access and management of accurate and relevant information including the continued development of the Integrated Payment and Reporting System (IPRS), the Medicaid Management Information System (MMIS), compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements, and development of a behavioral health care management system for the new psychiatric hospital.

Person-Centered Planning

Person-centered planning is fundamental to determining real life outcomes and developing strategies to achieve those outcomes for adult consumers and children/families. The key values and essential elements of any person-centered plan are defined in the Division's Communication Bulletin #34 (March 2005) along with documentation elements and indicators to demonstrate that person-centered planning has occurred. This chapter outlines those basic principles.

Quality Management

The purpose of quality management in the mh/dd/sas system is to support the achievement of the goals of reform. This chapter outlines for the first time the Division's principles of quality management (QM) and an overview of the comprehensive QM system. It introduces the roles and responsibilities of consumers and family members, of providers, LMEs, state operated facilities, the Division and the Department. It specifies how QM activities will be coordinated across local and state levels and across agencies to ensure successful progress toward individual and system goals. The QM system, which is under development, is based on the Quality Framework for Home and Community-Based Services developed by CMS, including functions of design, discovery, remediation and improvement.

An Action Plan for Cultural Competence

In March 2004, the Secretary of DHHS sponsored a one-day cultural competency workshop with a professional and ethnic cross section of citizen experts representing four racial/ethnic groups from across the state. This set the stage for the work of the Division's Cultural Competence Advisory Group resulting in a cultural and linguistic competency action plan. The chapter provides the background and a framework for future recommendations to the Division, LMEs, providers of services and other stakeholders on the delivery of culturally and linguistically competent services for consumers. The chapter presents definitions and guiding values and principles for organizations, practice and service design, and community engagement.

Evidence Based, Emerging and Promising Practices

State Plan 2003 identified three primary values for transforming the system: (1) investing for results, (2) "no wrong door" to services and supports, and (3) commitment to quality. These values require focus on the content and quality of the services and supports offered. That focus requires adherence to evidence based practices and fidelity to specific program models that are shown to produce consistently cost effective results. This chapter addresses how the Division will implement best practices in North Carolina through best practice disabilities committees and annual best practice collaborative meetings.

Goals for State Fiscal Year 2005-2006

Thirty-five key developments have been identified for state fiscal year 2005-2006 that will enable the Division to continue the transformation process. These key developments have been categorized into four areas: Management and Leadership, Finance, Programmatic Issues and Administration and Contracts. The specific developments for each of the four areas are described in the chapter.

This year's State Plan contains a list of acronyms and a glossary of terms most frequently used in this and other Division documents. For a more extensive list, see the Division's web site at http://www.dhhs.state.nc.us/mhddsas/.

Introduction

State Plan 2005 provides information for the people of North Carolina on the continuing efforts to reform North Carolina's public mental health, developmental disabilities and substance abuse services system. This plan provides a summary of reform efforts over the previous four years and outlines the key developments that will occur during state fiscal year 2005-2006.

This year's State Plan is organized into eight chapters.

Chapter 1: Foundations of Reform – This chapter provides an overview of reform and a brief review of state plan publications of prior years. It reiterates the mission, principles and vision of the Division and a description of the target populations.

Chapter 2: Organizational Structure of the Public MH/DD/SA Services System – This chapter provides a detailed description of the organization and structure of the public system.

Chapter 3: Transformation of the North Carolina MH/DD/SA Services System – This chapter answers the question "What have we accomplished since State Plan 2001?" It provides a status report on reform related developments affecting the community system, state facilities and the Department of Health and Human Services.

Chapter 4: Person-Centered Planning – This chapter focuses on the importance of person-centered planning in reform and outlines its key values and principles.

Chapter 5: Quality Management – This chapter discusses the principles of quality management and an overview of the process, roles and responsibilities, coordination and current statewide quality management initiatives.

Chapter 6: Cultural Competence – This chapter provides the background and the Division's development of an action plan for the delivery of culturally and linguistically competent services to the residents of North Carolina.

Chapter 7: Evidence Based, Emerging and Promising Practices – This chapter describes the activities of the Division and its advisory groups involved in research, literature review, evaluation and implementation of best practices in North Carolina.

Chapter 8: Goals for State Fiscal Year 2005-2006 – This chapter outlines the key tasks and initiatives to be addressed during state fiscal year 2005-2006 to continue to move reform forward. These initiatives have been categorized into four areas: management and leadership, finance, programmatic issues, and administration and contracts.

Chapter 1. Foundations of Reform

Introduction and Overview

The North Carolina General Assembly has mandated significant reform in the way that publicly funded mental health, developmental disabilities and substance abuse (mh/dd/sa) services are managed and delivered in the state. The primary elements of the reform are designed to ensure that public funding supports a service system that provides consumers, families and communities with necessary services and appropriate supports to facilitate community-based recovery from mental health and substance abuse disorders, and safe community-based choices that enhance the ability of individuals with developmental disabilities to exercise self-determination and achieve their maximum potential. The Division is committed to ensuring that best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant national consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and families.

Transforming the statewide mental health, developmental disabilities and substance abuse services system has been a massive and dynamic process. Since November 2001 the Secretary of the Department of Health and Human Services (DHHS), in conjunction with the executive leadership and staff of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) together with the Joint Legislative Oversight Committee on MH/DD/SAS (LOC) have been working to identify and implement strategies to transform the system by addressing issues related to state and local governance, increasing accountability at the state and local level and receiving input from stakeholders to ensure that the public system achieves the goals of reform.

The Division has been working on transition requirements that include development of the State Plan updated annually, establishment of the State Consumer and Family Advisory Committee, increasing participation by consumers and families, identification and implementation of target populations, addressing the utilization of state facilities and provision for better access to services; reduction of the number of area authorities to ensure economies of scale and scope; and outlined requirements and approval of local business plans and increased oversight of area/county programs.

Our partners at the local level have also been working on transitional issues to move toward a reformed system. Their accomplishments have included developing local business plans, establishing local consumer and family advisory committees (CFACs), divesting of services, recruiting providers, developing 24/7/365 access and screening capacity, completing mergers and cooperative agreements to increase efficiency and economies of scale and working to implement an LME structure. These policy objectives are consistent with the final report from President Bush's New Freedom Commission on Mental Health, the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) system improvement objectives, the

President's Commission on Mental Retardation and the U.S. Supreme Court's Olmstead decision.[2]

State Plan 2001: Blueprint for Change initiated the first major reform of North Carolina's mental health, developmental disabilities and substance abuse services system in more than thirty years. The State Plan was developed in response to the passage of HB 381. The legislation called for sweeping reforms in the service delivery system over a five-year period. State Plan 2001 centered on establishing an understanding of reform to include focusing the state's limited resources on those who are the most severely disabled.

State Plan 2002 Blueprint for Change continued the central themes of *State Plan 2001*. In addition, the Plan outlined and clarified key policy issues, fleshed out details, responded to concerns and reported on progress since the release of *State Plan 2001*. This first revision contained technical documents describing business plans for both state and local service systems, an overview of the Division's reorganization, staff competencies and a quarterly report to the Legislative Oversight Committee.

State Plan 2003 Blueprint for Change provided further refinement of the policy issues and established a course for developing some of the products and processes necessary to continue the momentum for reform. This second revision addressed the questions "Why are we reforming the system?", "Where are we going?", "Who are we to support and serve?", "What are the supports and services to be provided?", "How are we to locally carry out the supports and services?", and "What is the state's role in supporting the efforts of reform?" This second revision also addressed the challenges of managing change presenting an overview of developments to date as well as a broad presentation of developments to occur in state fiscal year 2003-2004.

State Plan 2004 Blueprint for Change provided details for the people of North Carolina on the key efforts to reform and transition the public mental health, developmental disabilities and substance abuse services system. This third revision reiterated the foundations of the reform efforts, reported on all system accomplishments since the enactment of the reform legislation and outlined an operations plan that included all of the major tasks and issues to be addressed in state fiscal year 2004-2005.

State Plan 2005: Blueprint for Change This fourth revision is designed to update the people of North Carolina on the transformation of the public mental health, developmental disabilities and substance abuse services system. During the past four years the foundations of reform have been laid through enhancing the organizational capacity of the Division, the community system and our state operated facilities. *State Plan 2005* addresses four areas that are fundamental to reform. These are person-centered planning, quality management, cultural competence, and evidence based, emerging and promising practices. Finally, the plan reports on the goals and key initiatives that will be undertaken during state fiscal year 2005-2006.

[2] See *Olmsted v. L.C., 119 S. Ct. 2176 (1999).*

Mission, Principles and Vision

The mission, principles and vision of the State Plan guide and inform North Carolina's reform effort through the great changes ahead and measure achievement and success. The road may be long, and change is hard, but the goal is worth all the effort.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Guiding Principles

- Treatment, services and supports to individuals and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on individual strengths, cost effective and reflect evidence based or best practices.
- Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.
- Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual planned in partnership with the individual and/or family.
- Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.
- System professionals will work with individuals and their families to help them get the most from services.
- Services shall meet measurable standards of safety, quality and clinical effectiveness at all levels of the mental health, developmental disabilities and substance abuse system and shall demonstrate a dedication to excellence through adoption of a program for continuous quality improvement.
- All components of the mental health, developmental disability and substance abuse system shall operate efficiently.

Vision

Public and social policy towards people with disabilities will be respectful, fair and recognize the need to assist all that need help.

The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.

System elements will be seamless; consumers, families, policy makers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

All human service agencies that serve people with mental health, developmental disabilities and substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.
- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Providers and managers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components.
- Access to an orderly, fair and timely system of arbitration and resolution.
- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided and that contain only these elements necessary to substantiate specific outcomes required.
- Training in services that are proven effective.

The People We Serve

Providing services to individuals with the most severe disabilities living in communities of their choice is the primary focus of the re-designed system. As directed by the North Carolina legislature, DHHS established criteria to identify individuals with various disabilities. The criteria include not only diagnostic[3] and functional elements but also circumstances unique to each

[3] Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

individual such as availability and access to appropriate services that meet the needs of each person.

The populations described in this section -- the target populations -- represent individuals with the most severe types of disabilities. The publicly sponsored mental health, developmental disabilities and substance abuse specialty system is committed to serving these populations. Several additional considerations are described below.

Anyone can seek services through the public system. The system's response includes screening, triage and referral, prevention and crisis services if needed. For individuals not in the target population who have the personal resources (insurance and ability to pay), the system's response could also include linking those persons to private providers for longer term services -- post crisis individual therapy, as an example.

Medicaid beneficiaries who have a condition that meets medical necessity for particular covered services are entitled to those services. These individuals are entitled to receive the supports, services, treatment and/or care regardless of whether they are identified as part of the state defined target populations. Medicaid beneficiaries who are not part of the state defined target populations, typically, require independent practitioner types of services that are less intensive and shorter term in duration. Medicaid beneficiaries who are included in the state defined target populations, generally, require supports, services, treatment and/or care that are more comprehensive, intensive and of longer duration.

Individuals who are part of the state defined target populations who are not Medicaid eligible will be served by the publicly sponsored specialty system. However, the provision of services to these individuals is not an entitlement as in the case of Medicaid beneficiaries. Thus, the publicly sponsored specialty system is challenged with managing its available resources to best meet the needs of these priority populations.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders, and treatment, services and supports need to be integrated across all disabilities. The target populations include the following.

Adult Mental Health

Approximately 5.4 percent of the adult population in North Carolina has a diagnosable mental health disorder that meets DSM criteria[4] accompanied by serious role impairment that has lasted for at least twelve months. Based on the projected estimate of adults 18 and above for 2003, about 343,217 North Carolinians have severe mental illness (SMI). With a +/- 0.9 percent margin of error, the number ranges from 228,092 to 456,183. About 2.6 percent (164,733 North Carolinians) are estimated to have severe and persistent mental illness (SPMI). The percentage of adults estimated to have any 12-month DSM disorder is 23.9 percent (or

[4] American Psychiatric Association, Diagnostic and statistical manual of mental disorders (4th edition, Washington, D.C., 2003.

1,519,055 North Carolinians). The estimates are based on a methodology established by a panel of experts convened by the federal Center for Mental Health Services.[5]

A more recent study conducted in 2001 by the National Household Survey on Drug Abuse (NHSDA) calculated the 12-month prevalence of serious mental illness as 7 percent (about 444,912 North Carolinians). Only about 47 percent of adults with SMI received treatment or counseling for a mental health problem during that same period.[6]

Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term "mental illness" can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illnesses. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target populations who seek services or who can be engaged through outreach activities. Eligibility for these target populations are described in the following tables. Additionally, priorities are established within target populations to guide the development and provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery approach focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

Priority Populations within Target Populations (This is an all inclusive list.)

- **Persons with multiple diagnoses**: Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.
- **Mentally ill adults in the criminal justice system**: Persons 18 or older with serious mental illness who are released from the Division of Prisons or are in local jails or on probation.
- **Elderly persons**: Persons age 65 and over with a serious mental illness, including dementia.
- **Deaf mentally ill persons**: Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.
- **Minorities**: Adults with severe and persistent mental illness who are disproportionately represented in the system.

[5] Federal Register, Vol. 64, No 121, June 24, 1999, pp. 33890-33897. The calculation of the estimates was based on the National Co morbidity Survey in 1990-1991 and the Epidemiologic Catchment Area Survey in 1980-1985.

[6] Office of Applied Studies, SAMHSA, The NHSDA Report, July 21, 2003.

Adult Mental Health Target Populations for Community Services

Persons with severe and persistent mental illness (AMSPM)

People in this target population include adults, ages 18 and over, who meet diagnostic criteria, and who as a result of a mental illness exhibit functioning that is so impaired as to interfere substantially with the capacity to remain in the community. The disability of these persons limits their functional capacities for activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Function status is assessed using the Global Assessment of Functioning (GAF). Level of functioning criteria includes:

Any client who has or has ever had a GAF score of 40 or below.

OR

Current client who never had a GAF assessment when admitted,

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

Current client who when admitted met level of functioning criteria but as a result of effective treatment does not currently meet level of functioning criteria,

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:

- Two or more psychiatric hospitalizations.

  or
- Two or more arrests.

  or
- Homelessness.

NOTE: an individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 40.

Persons with serious mental illness (AMSMI)

These are adults, ages 18 and over, who have a mental, behavioral or emotional disorder that can be diagnosed and that substantially interferes with one or more major life activities. Examples of these disorders include psychotic disorders, dementia and disorders such as obsessive-compulsive disorders, panic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF. Level of functioning criteria includes:

Any client who has or has ever had a GAF score of 50 or below

OR

Current client who never had a GAF assessment when admitted,

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

Current client who when admitted met level of functioning criteria but as a result of effective treatment does not currently meet level of functioning criteria,

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:

- two or more psychiatric hospitalizations;
  or
- two or more arrests;
  or
- Homelessness.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 50.

Adult deaf or hard of hearing (AMDEF)

Adult, ages 18 and over, assessed as having special communication needs because of deafness or hearing loss and having a qualifying mental health diagnosis.

Adult homeless – PATH (AMPAT)

Adult, ages 18 and over, with a serious long-term mental illness or a serious long-term mental illness and substance abuse diagnosis and is:

Homeless – as defined by:

Lacks a fixed, regular and adequate night-time residence

OR

Has a primary night-time residence that is:

- Temporary shelter.

  or

- Temporary residence for individuals who would otherwise be institutionalized.

  or

- Place not designed/used as regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

(1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility,

AND

(2) Who lacks resources to obtain and/or maintain housing.

Adult Mental Health Target Populations for State Hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

Primary populations to be served among state hospitals

- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.
- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring long-term inpatient rehabilitative treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.
- Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.
- Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.
- Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.

Specialty populations to be served

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Consumers who are deaf requiring acute or long-term inpatient psychiatric services.

Adult Mental Health Target Populations for the NC Special Care Center

The mission of the NC Special Care Center is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

Primary populations to be served

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).
- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

Specialty population to be served

Consumers with mid-stage Alzheimer's disease requiring nursing care.

Child Mental Health

Approximately 10 to 12 percent of the state's children experience serious emotional disturbance (SED). Based on the projected population of children aged 17 and younger for 2003, between 205,137 and 246,164 North Carolina children experience SED. The estimates adjusted for percent in poverty are based on a methodology established by a panel of experts convened by the federal Center for Mental Health Services.[7]

Child with early childhood disorder (CMECD)

Children, from 3 years through 5 years of age who demonstrate significantly atypical behavioral, socio-emotional, motor or sensory development such as:

1. Diagnosed hyperactivity, attention deficit disorders, autism spectrum disorders, severe attachment disorders, other pervasive developmental disorders, or other behavioral disorders.

2. Have indicators of emotional and behavioral disorders such as:
    a. Delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability to communicate emotional needs, or ability to tolerate frustration;
    b. Persistent failure to initiate or respond to most social interactions;
    c. Fearfulness or other distress that does not respond to comforting by caregivers;
    d. Indiscriminate sociability, for example, excessive familiarity with relative strangers, or
    e. Self-injurious or other aggressive behavior.

3. Have substantiated physical abuse, sexual abuse, or other environmental situations that raise significant concern regarding the child's emotional well being.

OR

Have documented presence of one or more of the following indicators associated with patterns of development, which have a high probability of meeting the criteria for developmental delay or atypical development as the child matures:

a. Parental substance abuse: Birth mother during pregnancy or primary care giving parent has been a habitual abuser of alcohol and/or drugs.
b. Parental mental retardation: Either parent has been diagnosed with mental retardation or developmental disability
c. Parental mental illness: Either parent has a diagnosed illness such as severe depression, bipolar illness, schizophrenia, or borderline psychotic conditions.

[7] Federal Register, 1998.

Seriously emotionally disturbed child with out-of-home placement (CMSED)

Children, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance that meets diagnostic criteria specified in ICD-9.

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school, or community activities as indicated by one or more of the following:

- Child and Adolescent Functional Assessment Scale (CAFAS) score of at least 90; OR
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; OR
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/Schools, DJJDP, DPH, DCD, or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had 3 or more psychiatric hospitalizations or at least 1 hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from 2 or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or 2 or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center, or jail within the past year.
- Situation exacerbated by special needs, (e.g., physical disability that substantially interferes with functioning).

NOTES: This target population was designed to cross walk with Level D in the Child Levels of Care document (March 2002).

An individual determined eligible for this target population has priority for funding if identified as: sexually aggressive, and/or, deaf, and/or having co-occurring disorders.

Seriously emotionally disturbed child (CMMED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school, or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; OR
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

NOTE: This target population was designed to cross walk with Level C in the Child Levels of Care document (March 2002).

Deaf or hard of hearing child (CMDEF)

Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss;

AND

The presence of a diagnosable mental, behavioral, or emotional disturbance that meets diagnostic criteria specified in ICD-9.

NOTE: Children who are deaf will be dually enrolled as both Deaf/HH and in their appropriate population category, in order to receive a full array of services. Where this funding is available, it will be depleted before other funding sources pay for the eligible service.

Homeless child – PATH (CMPAT)

Children, under the age of 18, who have serious emotional disturbance (SED), and have an ICD-9 diagnosis(es) and are:

Homeless – as defined by:

Lacks a fixed, regular and adequate night-time residence

OR

Has a primary night-time residence that is:

- Temporary shelter.

  or

- Temporary residence for individuals who would otherwise be institutionalized.

  or

- Place not designed/used as regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

(1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility,

AND

(2) Who lacks resources to obtain and/or maintain housing.

NOTE: There is no specific requirement regarding functioning as measured by a CAFAS score. Assertive outreach can be provided to homeless persons who have a deferred diagnosis.

Developmental Disabilities

The Division's developmental disabilities services follow recommendations of the National Association of State Directors of Developmental Disabilities Services and use the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. This means that there are approximately 130,810 people in NC with developmental disabilities.

Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

Adult with developmental disability (ADSN)
Adult, ages 18 and over, screened eligible as developmentally disabled in accordance with the current functional definition in GS 122C-3(12a). Developmental Disability Assessment based on NC Support Needs Assessment Profile (SNAP) 1 through 5.

Child with developmental disability (CDSN)
Child, under the age of 18, screened eligible as developmentally disabled in accordance with the current functional definition in GS 122C-3(12a) Developmental Disability Assessment based on NC SNAP 1 through 5.

Substance Abuse

Based on the North Carolina needs assessment household survey conducted by the Research Triangle Institute in 1995, six percent of North Carolinians aged 18 and above are in need of comprehensive treatment for alcohol or illicit drug use, while 14 percent are in need of some form of services. Based on population projections for 2003, this means 381,353 North Carolinians are in need of comprehensive treatment services, while 889,823 are in need of some form of services.

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children and youth under age 21 can be kept from smoking cigarettes, using illicit drugs and abusing alcohol, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Adult Substance Abuse

Adult injecting drug user/communicable disease (ASCDR)

Injecting Drug Users, those with Communicable Disease and/or those Enrolled in Opioid Treatment Programs, are those adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and:

- Who are currently (or within the past 30 days) injecting a drug under the skin, into a muscle, or into a vein for non-medically sanctioned reasons and who meet ICD-9 criteria for a substance-related disorder;

OR

- Who are infected with HIV, tuberculosis, or hepatitis B, C, or D and who meet ICD-9 criteria for a substance-related disorder;

OR

- Who meet ICD-9 criteria for dependence to a opioid drug, are addicted at least one year before admission, are 18 years of age or older, and who are enrolled in an opioid treatment program.

Adult substance abuse women (ASWOM)

Adult women who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 Substance-Related disorder who are:

Currently pregnant.

OR

Have dependent children under 18 years of age.

OR

Who are seeking custody of a child under 18 years of age.

Adult substance abuse DSS-involved parents (ASDSS)

DSS Involved adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and are substance abusers who meet ICD-9 criteria for substance-related disorder include those who:

(1) Are parents who have legal custody of a child or children under 18 years of age;
AND

(2) Where there is a Child Protective Services report for child abuse, neglect, or dependence that is being assessed, or where there is a finding of a need for Child Protective Services or a case decision of substantiation by Child Protective Services, OR who are authorized by DSS to receive Work First Assistance and/or services.

OR

Are DSS involved individuals who have been convicted of a Class H or I Controlled Substance Felony in North Carolina, and who are applicants for or a recipient of food stamps.

Adult substance abuse high management (ASHMT)

High management adult substance abusers, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance dependence disorder, are those individuals who are ages 18 and over, and who:

4. Are currently involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).

OR

5. Are currently admitted with an Axis I principal alcohol or substance dependence diagnosis to an inpatient hospital or residential treatment facility, a state operated hospital or alcohol and drug abuse treatment center (ADATC), or a non-hospital medical or social setting detoxification facility, or have been discharged with an Axis I principal alcohol or substance dependence diagnosis from any of these facilities within the past 30 days.

OR

6. Have a substance use pattern of recurring episodes of chronic use with unsuccessful attempts at recovery (or unsuccessful attempts by the provider to engage the chronically ill individual in treatment),

AND

Have a history of one or more unsuccessful treatment episodes, which may include assisted detoxification.

OR

7. Have an Axis I principal substance dependence diagnosis of one or more stimulant drugs, such as cocaine, amphetamine, or methamphetamine, are advanced in their addictive disease, have limited social or environmental supports, and have few coping skills. The individual may additionally be resistive to treatment or unsuccessful in engagement in a self-help, recovery, or peer support group such as AA or NA or a faith-based recovery program, or have co-occurring disorders, or have moderate biomedical conditions.

Adult substance abuse deaf and hard of hearing (ASDHH)

Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and who have an ICD-9 substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.

Adult substance abuse criminal justice offender (ASCJO)

Substance abusing Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who are involved in the criminal justice system, and:

(1) Who meet ICD-9 criteria for a substance-related disorder;
AND

(2) Whose services are approved by a TASC Program Care Manager;
AND

(3) Who voluntarily consent to participate in substance abuse treatment services;
AND

(4) Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Adult substance abuse driving while impaired treatment (ASDWI)

Adults, ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who have an ICD-9 substance-related disorder, and:

Have been arrested for

- Driving while impaired (DWI), OR
- Commercial DWI, OR
- Driving while less than 21 years old after consuming alcohol or drugs.

AND

Must have completed a DWI Assessment and been identified with a substance abuse handicap.

AND

Client must pay for initial $125 in fees for assessment and treatment.

AND

Have an income level of 200% or less of the federal poverty level.

Note: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Adult substance abuse homeless (ASHOM)

Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and who meet the criteria for any of the following IPRS target population categories:

- Injecting drug user/communicable disease risk (ASCDR).
- Criminal justice offender (ASCJO).
- DSS involved (ASDSS).
- DWI treatment (ASDWI).
- High management (ASHMT).
- Women (ASWOM).
- Deaf and hard of hearing (ASDHH).

AND

Homeless – as defined by:

Lacks a fixed, regular and adequate night-time residence

OR

Has a primary night-time residence that is:

- Temporary shelter.

  or
- Temporary residence for individuals who would otherwise be institutionalized.

  or
- Place not designed/used as regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

(1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility,

AND

(2) Who lacks resources to obtain and/or maintain housing.

Child and Adolescent Substance Abuse

Child with substance abuse disorder (CSSAD)

Child or adolescent, under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, with a Primary ICD-9 Substance-related disorder.

Child Substance Abuse Women (CSWOM)

Adolescent women who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, with a Primary ICD-9 Substance-Related disorder, and who are:

Currently pregnant.

OR

Have dependent children under 18 years of age in her custody or for whom she is seeking such custody.

Child substance abuse selective prevention (CSSP)

Child or adolescent, under the age of 18, who is determined to be at elevated risk for substance abuse and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion, or dropping out of school; OR
- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort; OR
- Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations, or substantiations involving DSS; OR
- Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse indicated prevention (CSIP)

Child or adolescent, under the age of 18, who is using alcohol or other drugs at a pre-clinical level, and who:

8. Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion, or dropping out of school; OR
9. Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort; OR
10. Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations, or substantiations involving DSS; OR
11. Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder.

Individuals do not meet ICD-9 criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for a "V" Code (Other Condition That May Be a Focus of Clinical Attention). Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse criminal justice offender (CSCJO)

Substance abusing adolescent clients who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, and who are involved in the criminal justice system and:

Who have a Primary ICD-9 substance-related disorder;

AND

Whose services are authorized by a TASC Program Care Manager;

AND

Who voluntarily consent to participate in substance abuse treatment services;

AND

Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Child substance abuse treatment for Impaired Driving Offenders (CSDWI)

Adolescents under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, who have a Primary ICD-9 substance-related disorder and:

Have been arrested for:

- Driving while impaired (DWI) OR
- Commercial DWI, OR
- Driving while less than 21 years old after consuming alcohol or drugs;

AND

Must have completed a DWI Assessment and been identified with a substance abuse handicap;

AND

Client must pay for initial $125 in fees for assessment and treatment;

AND

Have an income level of 200% or less of the federal poverty level.

NOTE: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Child in the MAJORS substance abuse/juvenile justice program (CSMAJ)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a Primary ICD-9 Substance-related disorder

AND

Is enrolled in the MAJORS Substance Abuse/Juvenile Justice Program.

Priorities within Substance Abuse Target Populations

- Adult and adolescent pregnant injecting drug users.
- Adult and adolescent pregnant substance abusers.
- Adult and adolescent injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients.
- All others within the target populations.

Persons with Substance Abuse and Mental Illness

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult mental health services shall have primary responsibility for mentally ill individuals who also abuse substances. This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression or borderline personality disorder, and in addition have a substance abuse problem.
- Substance abuse services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. This includes adults who carry a diagnosis of substance abuse/dependence and, in addition, have a mental health diagnosis other than those listed above, which could include other Axis II disorders.

Chapter 2. Organizational Structure of the System

The Joint Legislative Oversight Committee on MH/DD/SAS

The North Carolina General Assembly established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) to oversee system reform. The Legislative Oversight Committee was instrumental in the creation and ratification of the mental health reform statute (House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level). Since the enactment of the reform legislation, the LOC has met on a regular basis to receive input from the leadership of the Department and the Division and from the public on the status of the reform efforts. During state fiscal year 2004-2005, the LOC met five times to discuss bills recommended by the LOC studies assigned to the committee, reviewed budget provisions from the Appropriations Act of 2004, and received presentations on initiatives of the Division. The LOC submitted a final report to the General Assembly of N.C. in January 2005.[8] In addition, the Division provides quarterly reports to the LOC on matters related to implementation of the reform.[9]

The North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (The Commission)

The Commission was established in 1973 by the General Assembly as a part of the Executive Organization Act (G.S. 243B). The 1985 Mental Health, Developmental Disabilities, and Substance Abuse Act extended the rulemaking powers and duties of the Commission. The 2001 Mental Health Reform Legislation (H381) revised and added sections of the Executive Organization Act and the MH/DD/SAS Act to assign added duties regarding human rights committees and rule adoption, changed the membership guidelines, provided additional duties of the Secretary of DHHS and added language for the creation of the state's plan for mh/dd/sas.

The Commission has two standing committees, the Rules Committee and the Advisory Committee. These committees were established to provide more informed recommendations to the full commission before action is taken by the entire body.

The Rules Committee reviews drafts of all proposed amendments and new rules including commission rules/amendments and DHHS Secretary rules/amendments. The Rules Committee works closely with Division staff with respect to the need for and adoption of a proposed rule or amendment.

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[8] This report can be found on the web at the following location: http://www.ncleg.net/committees/jointlegislativ/locreports/loc2005reportto/loc2005reportto.pdf.

[9] Quarterly reports can be found on the web at: http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.

The Advisory Committee studies the service delivery system and the operation of the Division for the purpose of making recommendations to the Commission. This process works to facilitate the Commission's ability to advise the Secretary of Health and Human Services and the Division Director.

The Commission advises the Secretary of Health and Human Services about the need for, provision and coordination of education, prevention, intervention, treatment, rehabilitation and other services in the area of mental illness, mental health, developmental disabilities and substance abuse. The Commission has authority to make rules for:

- Operating local area mental health, developmental disabilities and substance abuse programs.
- Admission, care and treatment of people in residential facilities operated by the Division.
- Licensing facilities for people with mental illness, developmental disabilities or substance abuse problems, including the professional requirements of staff.
- Registration and control of the manufacture, distribution and dispensing of controlled substances.
- Implementing clients' rights law.
- Establishing human rights committees.
- Mental health and mental retardation services for people in the custody of the Department of Correction.

There are 30 members on the Commission, each serving a three-year term. Each congressional district has at least one representative on the Commission. The Governor appoints 24 members and the General Assembly appoints six members.

The Department of Health and Human Services (DHHS)

The mission of the North Carolina Department of Health and Human Services (DHHS) is to serve people of North Carolina by enabling individuals, families, and communities to be healthy, secure and to achieve social and economic well being. DHHS is the largest agency in state government responsible for ensuring the health, safety and well being of all North Carolinians, providing the human services needs for populations like those with mental illness, developmental disabilities and substance abuse problems and helping North Carolinians living in poverty to achieve economic independence. The Department touches the lives of virtually every North Carolinian from birth to old age through prenatal programs, child development programs, and adult care home regulation. Administratively, it is divided into 24 divisions and offices, 19 facilities and the Town of Butner, which all fall under four broad service categories-administration, support, health and human services. The Department is responsible for a number of broad policy initiatives affecting large numbers of North Carolinians. Some of the highest profile programs are tied to DHHS-including Smart Start, N.C. Health Choice for Children, Work First, and the Crackdown on Deadbeat Parents.

DHHS is under the leadership of a Secretary who is appointed by the Governor, is exempt from the State Personnel Act and is a member of the Governor's Cabinet. The Office of the Secretary is responsible for providing leadership, guidance, direction and management. There are over 18,000 employees of the Department and its budget represents roughly 20% of the state's total budget.

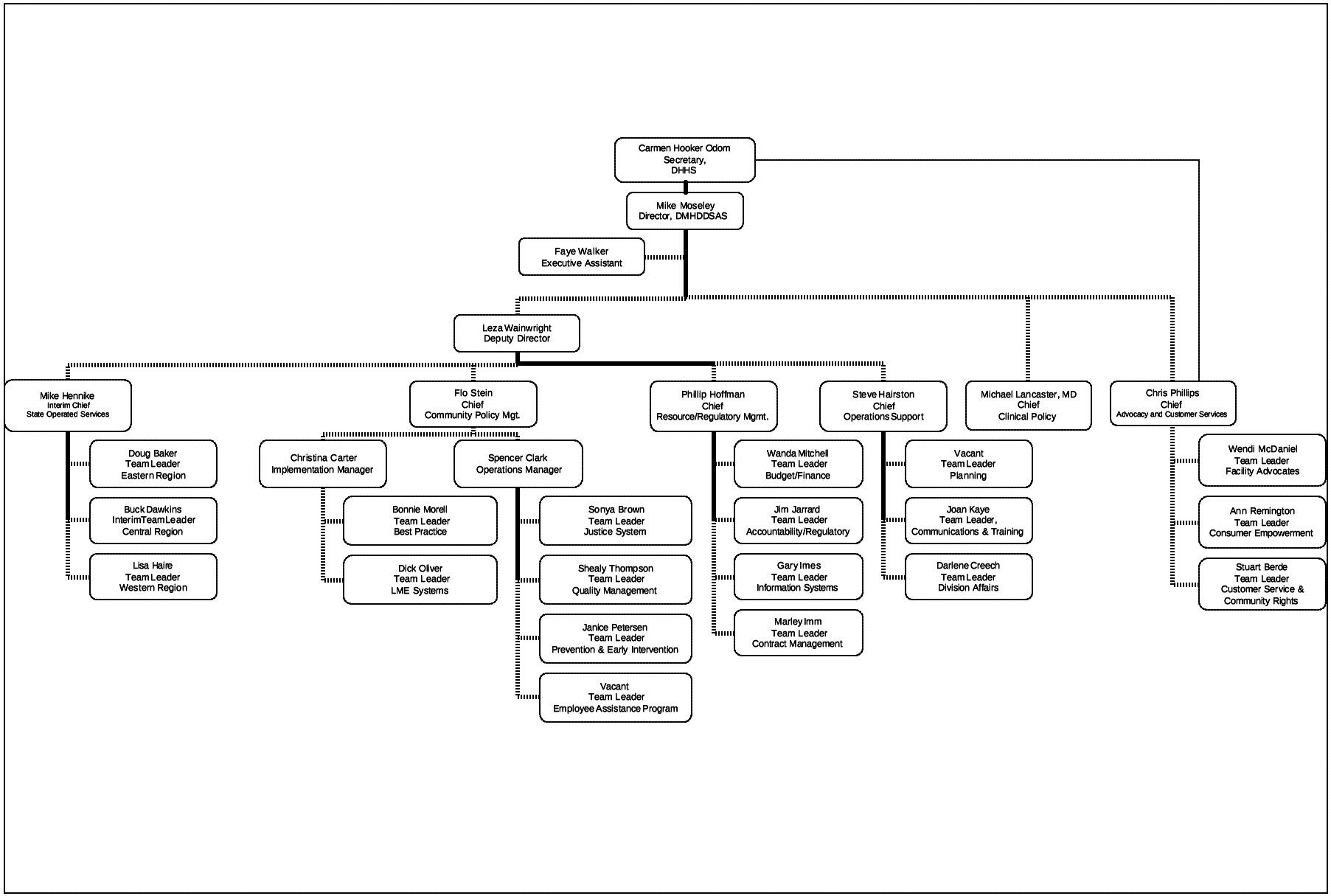
The Division of MH/DD/SAS

The Division's organizational structure is designed to implement the State Plan and reform efforts. The substance of the Division's goals and objectives will guide the development of the workings of the Division and that work will be carried out through this organizational structure.

The Division's central administration consists of the Director's Office and five sections organized along functional lines. The five sections of the Division are State Operated Services, Community Policy Management, Resource/Regulatory Management, Advocacy and Customer Services, and Operations Support. The Division's state facilities consist of four regional psychiatric hospitals, four developmental disabilities centers, three substance abuse treatment centers, a specialty nursing facility for mentally ill consumers, a specialty nursing facility for consumers with developmental disabilities and two residential facilities for children with emotional disturbances.

An organization chart and detailed descriptions of the functions and duties of the Director's office and each section of the Division are provided on the following pages.

N.C. DHHS – Division of Mental Health, Developmental Disabilities and Substance Abuse Services



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Executive Assistant to Mr. Moseley

Patti Escala
Executive Assistant

The vision, mission and guiding principles are the substance of the organization – where we are going, what we are dedicated to do and what we adhere to in all of our efforts.

Sylvia Crumpler
Human Resources Manager

3017 Mail Service Center
Raleigh, NC 27699-3017
(919) 733-4416

The Director's Office provides strategic and operational leadership and oversight for the public MH/DD/SAS system. This office sets the overall policy direction of the Division under the supervision and leadership of the Secretary of the Department of Health and Human Services (DHHS). The Division Director seeks the involvement of all stakeholders in the public services. Clinical leadership ensures the quality and effectiveness of service delivery and the continuum of care and strengthens the clinical relationship between the public, private and academic sectors.

The Division's organizational structure is intended to promote the expectations articulated in the vision, mission and guiding principles. Providing services to individuals with the most severe disabilities in communities of their choice is the primary focus of the re-designed system.

Transformation of the public MH/DD/SAS is being implemented through a process of comprehensive examination, collaboration and modification that results in a revised State Plan presented at the beginning of each state fiscal year. To meet the requirements of the State Plan and reform, key developments are identified for each state fiscal year.

Community Policy Management

Chief
Flo Stein

Implementation Manager
Christina Carter

Operations Manager
Spencer Clark

3700 Mail Service Center
Raleigh, NC 27699-3007

This section is primarily responsible for leadership, guidance and management of relationships with the local management entities (LMEs). It is recognized as the responsible public policy leadership and oversight agent for community-based services.

This section collaborates with a wide variety of public and private partners and customers, to promote recovery through the reduction of stigma and barriers to services. Special emphasis is placed on relationships with federal departments and agencies.

This section performs the functions of the single state agency (SSA) for substance abuse and of the state methadone authority. Teams of this section include:

Employee Assistance Program (EAP) Provides support for Department employees and their families and influences the development of effective EAPs in communities.

Quality Management Team The primary purposes are to establish the standards of quality and required performance measures specifying how quality is defined, monitored and managed; to evaluate system performance; and to coordinate improvement processes.

Best Practice and Community Innovations Team The primary purposes are improving and strengthening the system through development of best practice platforms and models and establishing a system that more effectively connects services and research, with the goal of providing treatment, services and supports based on the best scientific evidence.

Local Managing Entity Systems Performance Team The responsibilities of this team include leading and coordinating the Division's efforts to develop, negotiate, monitor and manage contracts with the local managing entities (LMEs); providing technical assistance to LMEs on all aspects of system reform; and coordinating across the Division teams to conduct scoped site reviews of LMEs when there is evidence of problems with specific areas of best practice or emerging best practice or compliance, performance and/or outcomes.

Justice System Innovations Team This team will continuously research, disseminate and advance relevant best practice and innovations in the areas of mental health, developmental disabilities, substance abuse and specialty supports and services for individuals involved in the criminal justice or juvenile justice system.

Prevention and Early Intervention Team Designated as the Office of Substance Abuse Prevention, this team will also develop an appropriate evidence based prevention framework for mental health and developmental disabilities. Responsibilities include early intervention services for children and coordination of many of the Division's financially related agreements, grants and contracts.

Resource/Regulatory Management

Chief
Phillip Hoffman

3700 Mail Service Center
Raleigh, NC 27699-3007
(919) 715-7774

This section is responsible for fulfilling the Division's needs for fiscal monitoring, accountability, and regulatory compliance, support of information technology and contracts management. Teams of this section include:

Budget and Finance Team This team is responsible for planning, developing, implementing and managing budget (expenditure) and finance (revenue) strategies for the Division's total budget. Emphasis focuses on changes in the service financing structure to maximize resources and support additional community capacity building.

Information Systems Team This team is responsible for planning, developing, implementing, managing and improving the Division's computer network, warehouse, hardware, software and technical support functions, including:

Management, maintenance and improvement of systems such as the state Health Enterprise and Accounts Receivable Tracking System (HEARTS) and Integrated Payment and Reporting System (IPRS) and all data sources.

Accountability and Regulatory Team This team is responsible for ensuring fiscal integrity within the Division including state-operated services and the community system and ensuring regulatory compliance.

Accountability is ensured by:

Monitoring Medicaid compliance standards in the field as well as in the Division's fiscal oversight.

Monitoring fiscal audit standards and financial regulatory standards in the field as well as the Division's efforts of fiscal oversight.

Monitoring fiscal audit standards and financial regulatory standards in the field as well as the Division's efforts of fiscal oversight.

Regulatory Compliance is ensured by:

Coordination of Medicaid waiver and State Plan developments with DHHS.

Management of Division responsibilities regarding Driving while Impaired (DWI) and drug enforcement.

Completion of pre-admission screening and annual resident reviews (PASARR).

Completion of Intermediate Care Facility-Mental Retardation (ICF-MR) level of care (LOC) determinations.

Completion of provider enrollments.

Provision of interpretations of federal and state regulations.

Contract Management and Development Team This team supports the implementation of the State Plan in three primary areas:

Ensuring contracts are performance based, monitored and developed in accordance with all state and federal requirements.

Ensuring compliance with all federal requirements related to block grants, cooperative agreements, contracts and other grants.

Managing property, maintenance, surplus disposal, purchasing and employee parking.

Advocacy and Customer Service

Chief
Chris Phillips

3009 Mail Service Center
Raleigh, NC 27699-3007
(919) 715-3197

This section is responsible for providing consumer advocacy leadership. It is responsible for:

Ensuring that state-operated services and community-based systems remain compliant with rights protections for recipients of supports and services,

Developing, maintaining and advancing relationships with advocacy organizations and

Ensuring that disability populations are adequately represented in the Division's planning, implementation, management and improvement efforts.

Consumers, family members and advocates are included in all functions of this section. Teams of this section include:

State Facilities Advocates Team

This team is responsible for ensuring that the rights of consumers in state operated facilities are protected. Advocates manage case investigations and negotiate system improvement efforts for residents of state operated facilities.

Customer Service and Community Rights Team

This team is responsible for ensuring the rights protection of consumers being served in the community, providing a response system for customer complaints and appeals, and monitoring the community customer service systems.

Staff members ensure that the rights of recipients are protected by monitoring client advocacy services and improving community rights protection systems. Staff works with local LME customer service offices to follow through on issues brought forward by customers and also monitors the efforts of the community services system.

Consumer Empowerment Team

This team is responsible for ensuring consumer and advocacy voice and disability representation in Division planning, implementation, management and improvement efforts by:

Providing technical assistance and consultation to the State Consumer and Family Advisory Committee (SCFAC).

Assisting in the development of local grassroots consumer controlled advocacy groups and organizations.

Providing technical assistance and consultation to local Consumer and Family Advisory Committees (CFACs).

Monitoring the efforts and achievements of the local CFACs to ensure their empowerment to perform their roles/responsibilities.

Operations Support

Chief
Steve Hairston

3014 Mail Service Center
Raleigh, NC 27699-3007
(919) 715-2780

This section is responsible for implementing the operational functions of the Division. It is responsible for all matters related to planning, rule and policy development, media relations, trainings and communication with external stakeholders. Teams of this section include:

Planning Team

This team is responsible for providing technical oversight and coordination in implementing and managing the operational functions of the Division.

Providing technical oversight and coordination and implementing and managing the State Plan and related projects.

Providing a range of technical planning assistance (from brief consultation to plan management) for all Division planning endeavors.

Serving in the role of project manager for specific initiatives.

Division Affairs Team

This team is responsible for advancing collaborative efforts among divisions of the Department.

Participating in and creating new partnerships to foster reform.

Coordinating the development of rules, policy and legislation with the Department.

Managing and monitoring Division programmatic *due process* appeals functions.

Staffing and supporting the commission of Mental Health, Developmental Disabilities and Substance Abuse Services.

Serving as liaison for select commissions, advisory councils and planning groups associated with the Division.

Communications and Training Team

This team is responsible for increasing public awareness regarding the efforts of the Division, particularly related to reform

Coordinating the media relations for the Division with the Department.

Developing and disseminating information and communications regarding Division activities (annual report, newsletters, brochures, etc.)

Developing a comprehensive training plan for advancing Division members' competencies in coordination with Human Resources.

Developing training opportunities necessary for carrying out reform efforts.

Serving as the liaison to universities, community colleges and Area Health Education Centers (AHECs) to facilitate training for the State Plan.

Developing strategies to address workforce issues.

Consumers, family members and advocates will be included in active and meaningful roles as regarding ongoing functions of this team

State Operated Services

Interim Chief
J. Michael Hennike

3006 Mail Service Center
Raleigh, NC 27699-3007
(919) 733-3654

The Division holds a dual role as manager and provider of state-operated services and facilities and is held to the same quality and best practice standards as are the local management entities (LMEs) in overseeing local service delivery.

This section is responsible for defining the purpose, roles and responsibilities of state operated facilities.

Developing a system for regional planning.

Carrying out administrative consolidation efforts that promote increased efficiencies and effectiveness as required by the reform statute and state 2001 appropriations bill.

Managing out-of-state placement and return of people being served.

Determining roles and responsibilities for developing partnerships with regional advocates, LMEs, area/county programs, counties, provider systems and Division stakeholders.

Managing admissions and discharge planning of state-operated facilities.

Making census reduction plans and corresponding budget reduction plans for state-operated services that include considerations of impact on state employment and efforts to work with local communities regarding economic implications.

Devising statewide standards for each type of state operated service (by disability group and within unique programs) that reflect best practice and emerging best practice and that are understandable, accountable, appropriate, efficient, effective and consistent with regulatory and accreditation compliance, performance and outcome expectations.

The State Facilities

State Psychiatric Hospitals and Special Care Center

The Division's psychiatric hospitals and its specialty long-term care facility provide inpatient services to people with disabilities within the state. These facilities are accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and are certified by the Centers for Medicare and Medicaid (CMS).

- Broughton Hospital, Morganton
- Cherry Hospital, Goldsboro
- Dorothea Dix Hospital, Raleigh
- John Umstead Hospital, Butner
- N.C. Special Care Center, Wilson

Mental Retardation/Developmental Disabilities Centers and Black Mountain Center

The four developmental centers are certified as Intermediate Care Facility/Mental Retardation (ICF/MR) level of care by CMS. Black Mountain Center is certified as a Nursing Facility level of care. The centers primarily serve adults with severe and profound mental retardation, many of whom have significant physical disabilities and/or medical fragility. Services provided by the centers include communication; recreational, occupational, and physical therapies; psychology; education; pharmacy; dietary; medical and advocacy. The centers are:

- Black Mountain Developmental Center, Black Mountain
- J. Iverson Riddle Developmental Center, Morganton
- O'Berry Developmental Center, Goldsboro
- Murdoch Developmental Center, Butner
- Caswell Developmental Center, Kinston

Alcohol and Drug Abuse Treatment Centers

The Alcohol and Drug Abuse treatment facilities provide residential treatment designed to meet the needs of alcohol and other drug dependent citizens of North Carolina. These ADATCs are:

- Julian F. Keith ADATC, Black Mountain
- Walter B. Jones ADATC, Greenville
- R. J. Blackley ADATC, Butner

Residential Programs for Children

The Division's two residential programs for children are:

- Wright School, Durham
- Whitaker School, Butner

Wright School serves children ages 6-12, focusing on treatment needs of school age children from around the state. Wright School uses a re-education model that teaches children appropriate ways of interacting in their environment. Wright School provides a staff-secure setting for treatment and has a staff on duty 24 hours a day to ensure appropriate supervision.

Whitaker School is a residential treatment center located on the grounds of John Umstead Hospital for youth ages 12-17. It serves adolescents statewide sing the re-education model. Children are encouraged to go home or to an alternative community placement on weekends. Whitaker is a locked, physically secure treatment setting with a staff on duty 24 hours a day to meet the needs of the children served.

LMEs/APs and Community Services

As directed in the state reform legislation, HB 381, the Division has included in each annual update of the State Plan a process for transforming the area authorities and county programs[10] from primarily service delivery organizations to service management organizations. The legislation obligated each county to decide on the form of local governance for mh/dd/sa services management. Once established, each public program is referred to as a Local Management Entity (LME). While LME is not a statutory term, it identifies the purpose of the public agency rather than describing its governance structure. While a county can be part of an area authority, a single county program, or part of an inter-local agreement, the function of these organizations as LMEs is the same.

Under the previous community system, area programs delivered a full range of services and also contracted for the delivery of services. Additionally, the area programs were responsible for coordinating and managing the quality and quantity of services in the community. As directed in HB 381, local programs have been working to remove these overlapping roles. LMEs are primarily intended to be management entities. Public services delivered directly by the area programs will be divested to private providers. In managing services, the LMEs are expected to perform a series of functions not previously expected of the area programs. These responsibilities include:

- Identifying the client base within each LME's catchment area.
- Understanding the need for community-based services and identifying service gaps.
- Recruiting providers.
- Contracting with qualified providers.
- Approving the person centered plans for individual clients.
- Establishing and supporting a local Consumer and Family Advisory Committee

In order to achieve this transformation from service provider to LME, the State Plan established a process and schedule for certifying newly created LMEs. This process included the statutory

[10] General Statute 122C-3 defines "area authority" as the area mental health, developmental disabilities and substance abuse authority. A "county program" means a mental health, developmental disabilities and substance abuse services program established, operated and governed by a county pursuant to G.S. 122C-115.1.

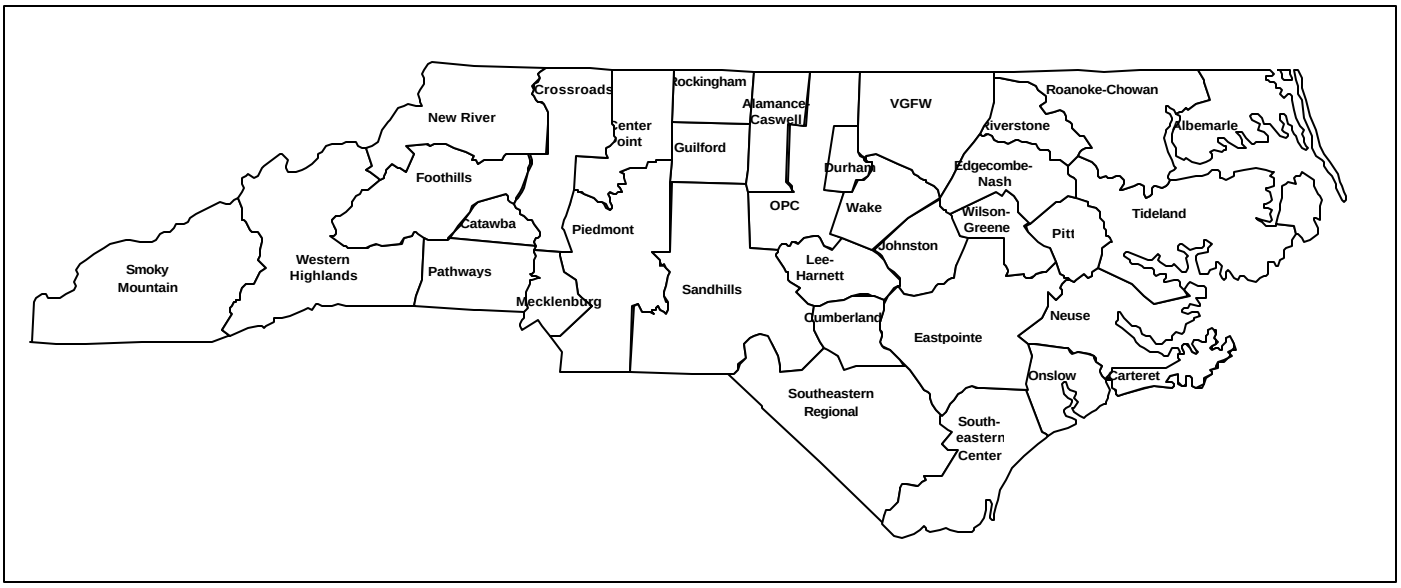
requirement that counties develop business plans for implementing and operating the reformed community system.

According to the local business planning requirements, counties work together to develop one business plan for each proposed LME. The local business plan describes characteristics of the LME's catchment area, including the client base and service gaps. The local business plan also addresses specifics regarding the LME's operation.

The Secretary is responsible for certifying each local business plan. Once certified, the LME is officially established and operational. The local business plan has a lifespan of three years, and then a new plan must be submitted. LMEs and the Department annually negotiate performance contracts addressing changes in the LME's service environment.

The original State Plan contemplated full transformation to the LME system by July 1, 2003. Currently, the number of area and county authorities has been reduced from 39 to 33 programs. Of the 33 programs, 29 are certified LMEs. All but four area and county programs have completed the transformation to LME.

Local Management Entities as of June 2005



Consumer and Family Advisory Committees

In order to address the consumer involvement requirements of HB 381, the initial State Plan directed each LME to create a Consumer and Family Advisory Committee (CFAC). Each CFAC is composed of individuals who are consumers or family members of consumers in the LME for each of the major disability groups. The CFAC advises the LME on all aspects of LME operations as well as the development and operation of the local service system. The State Plan requires that a CFAC be in place and approve the LME's local business plan as a condition of LME certification. The expectation is that the CFAC will meet regularly and play a prominent role in the LME's decision-making process. In addition to local CFACs, a state-level CFAC has been established to inform the Department regarding operations of the mh/dd/sa service system. (See http://www.dhhs.state.nc.us/mhddsas/scfac/index.htm)

Chapter 3. Transformation of the NC MH/DD/SA Services System

The first major reform of North Carolina's public system in more than thirty years was developed in response to the passage of HB 381. Over the past four years staff of the Division has been working to develop the infrastructure needed to enact this sweeping legislation. This chapter provides a status report on activities to date to phase-in implementation of reform.

Transformation of the Community System

Performance Contract

During state fiscal year 2004-2005, DHHS (including the divisions of Mental Health, Developmental Disabilities and Substance Abuse Services, Medical Assistance, and the Office of the Controller), the N.C. Council of Community Program and the N.C. Association of County Commissioners (NCACC) negotiated a statewide performance contact between the Department and the LMEs. This contract, which is anticipated to develop over time, currently contains each LME's local business plan (LBP) as the scope of work, statewide requirements, performance measures and financing requirements. Division staff worked with each LME to incorporate its LBP into the final contract and secure signatures. While the contract did not address all issues that various stakeholders wished to see included, DHHS and the LMEs are committed to working on a development plan that will add requirements to the contract over the next several years as LMEs continue to transition their role of managers of service and public policy at the local level.

Area Authority/County Program Catchment Area Consolidation Plan

Section 3 (a) (8) of HB 381, An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, requires the Secretary of the DHHS to develop a catchment area consolidation plan. The legislation calls for the Secretary to develop a plan that results in a "target of no more than 20 area authorities and county programs." In doing so, the legislation directs the Secretary to consider the letters of intent received from boards of county commissioners, the capacity of programs to implement the business plan, and "geographic and population targeted thresholds" in developing the plan. The completed plan was to be submitted to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, the Governor and each board of county commissioners. The report was submitted, as required, on February 14, 2005.

The functions to be performed by area/county programs as managers of services at the local level are very different from the functions that the programs previously performed as service providers. As area authorities developed and started to implement their local business plans, some small to mid-size programs came to an immediate understanding of the importance of the cost efficiencies and economies of scale, as well as the increased staff expertise, that could be gained through consolidation of programs. Those programs began immediate conversations with potential partners.

When HB 381 was ratified the state was served by 40 area authorities. By July 1, 2005 that number has been reduced to 33 and by July 1, 2006 will be reduced to 29 through voluntary consolidations. The programs that have completed or are engaged in consolidation activities currently are:

Consolidated Program	Programs Consolidated	Counties Served
Completed Consolidations		
Eastpointe	Duplin-Sampson, Lenoir, Wayne	Duplin, Lenoir, Sampson, Wayne
Piedmont	Piedmont, Davidson	Cabarrus, Davidson, Rowan, Stanly, Union
Western Highlands	Blue Ridge, Rutherford-Polk, Trend	Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey
Partially Completed Consolidations		
Sandhills (Sandhills/Randolph complete, Lee-Harnett 7/1/2005)	Sandhills, Randolph, Lee-Harnett	Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
Pending Consolidations		
(Not yet named)	Alamance-Caswell, Rockingham	Alamance, Caswell, Rockingham
Onslow/Carteret Behavior Healthcare	Onslow, portion of Neuse	Carteret, Onslow
(Not yet named)	Edgecombe-Nash, Wilson-Greene	Edgecombe, Greene, Nash, Wilson
Five County Mental Health Authority	VGFW, Riverstone	Franklin, Granville, Halifax, Vance, Warren

In recognition of the significant changes currently taking place in the public mh/dd/sa services system (i.e., transition of service delivery from the area authorities to other public and private providers, direct enrollment in the Medicaid program for all providers, implementation of new service definitions and benefit packages that reflect evidence-based best practice, implementation of person-centered planning for all disabilities, requirement for increased involvement by consumers and family members in the service delivery system, etc.), DHHS does not believe that it would be possible or prudent to force the consolidation of programs that do not choose to merge voluntarily. In taking this position, we also note that the reform legislation gave counties the option of choosing to operate a single county program, regardless of population size (G.S. 122C-115.1), which limits the ability of the DHHS to force mergers of single county programs.

As programs continue to evolve into LMEs some of the programs that have been resistant to consolidation thus far may conclude that it is not practical or effective to remain autonomous. However, the DHHS also recognizes that there are issues other than geographic or population size that can affect the ability of a program to fulfill its obligations as a LME and that there are

factors other than consolidation that may address cost efficiencies. Some single county programs receive significant infrastructure support from their county government such that they do not require the level of state funding to support LME functions that a freestanding area authority of the same size might require. In addition, LMEs are beginning to discuss other means of creating economies of scale and increased efficiency by collaborating in certain expenditures or LME function, without entering into full, formal mergers.

The DHHS will continue to work with area/county programs to address opportunities for cost efficiencies, including opportunities for consolidation. At the same time, through the performance-based contact, we will continue to increase the outcomes that programs must achieve. We believe that these combined activities will result, over time, in the "right sizing" of the community system, without the need to force consolidations.

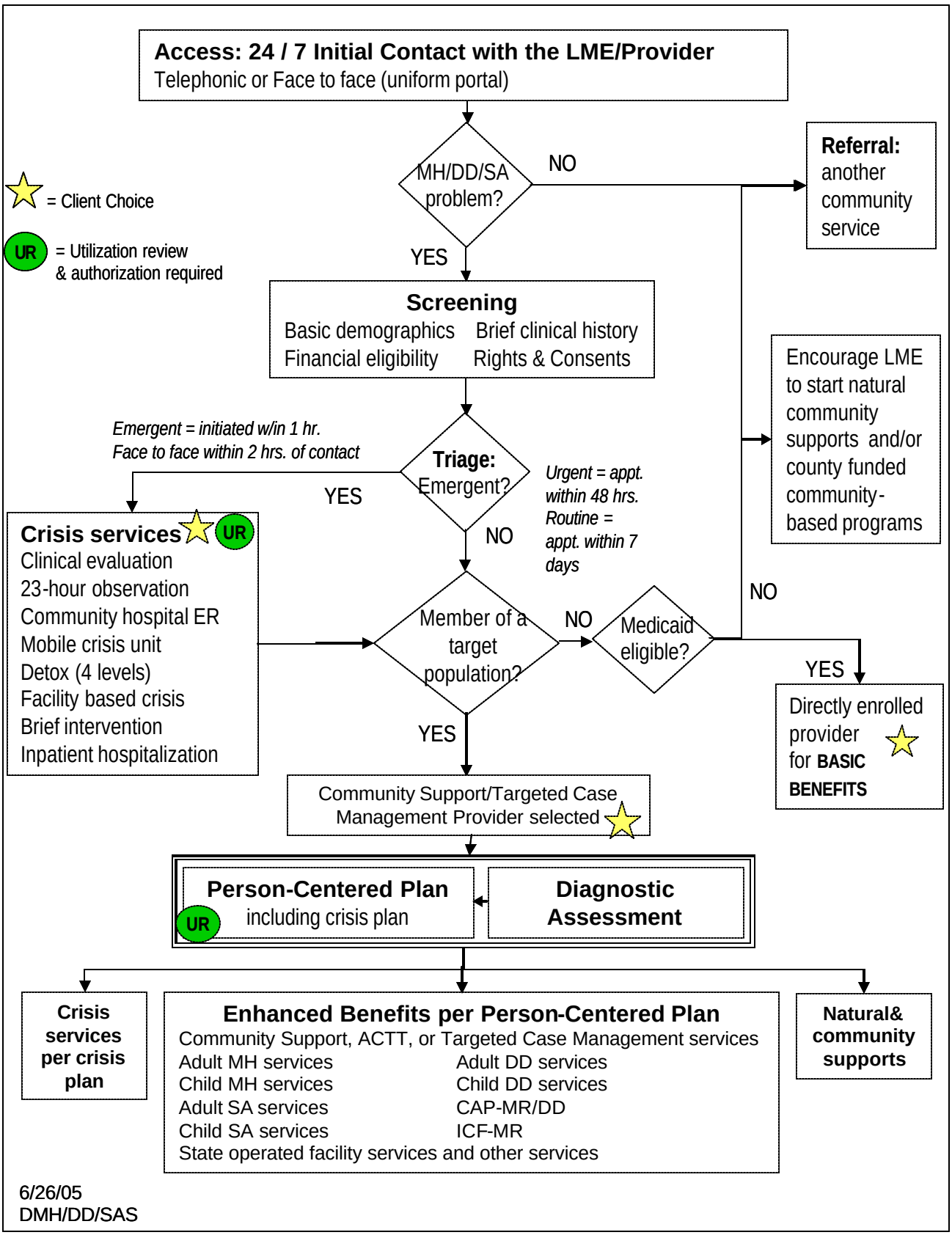
Community Based Crisis Stabilization Services

In March 2005, the Division published Communication Bulletin #35, *Policy Guidance: Development of Community Based Crisis Stabilization Services*.[11] That document provides alternative ways of organizing crisis services for consideration by LMEs and clarifies the relationship of local crisis services to an LME's responsibility for access/screening/triage. The following flow chart depicts that process and continues with selection of the clinical home provider (such as Community Support, ACT Team or Targeted Case Management) to assist members of target populations with person-centered planning for enhanced services. See the document for detailed protocols for access/screening/triage/referral and description of uniform portal design and staff qualification requirements.

The document addressed the DHHS-LME Performance Agreement, Section 4.3 of Attachment II Statewide Requirements that was effective July 1, 2004. Each aspect of that requirement is elaborated in the document. That section states: "The LME shall maintain a 24-hour, seven days a week crisis response service. Crisis response shall include telephone and face to face capability. Crisis phone response shall include triage and referral to appropriate face to face crisis providers and shall be initiated within one hour. Crisis services do not require prior authorization but shall be delivered in compliance with LME policies and procedures. Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety."

By clarifying expectations about the provision of crisis services, the Division also addressed the increased utilization of state psychiatric hospitals and gave recommendations for the development of community capacity to better meet the needs of people in the catchment area. Many clients who are currently served by the state hospitals can be served effectively in community based settings without the need for hospitalization. Others, however, require brief hospital or crisis unit stays. When crises arise, the LME must have the capability to appropriately respond within its provider system to an emergent situation within two hours, an urgent situation within 48 hours and a routine situation within seven days.

[11] See the Division's web site: http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.


Access: 24 / 7 Initial Contact with the LME/Provider
Telephonic or Face to face (uniform portal)
MH/DD/SA problem?
NO
YES
Referral: another community service
= Client Choice
UR = Utilization review & authorization required
Screening
Basic demographics
Brief clinical history
Financial eligibility
Rights & Consents
Encourage LME to start natural community supports and/or county funded community-based programs
Emergent = initiated w/in 1 hr.
Face to face within 2 hrs. of contact
Triage: Emergent?
YES
NO
Urgent = appt. within 48 hrs.
Routine = appt. within 7 days
Crisis services
Clinical evaluation
23-hour observation
Community hospital ER
Mobile crisis unit
Detox (4 levels)
Facility based crisis
Brief intervention
Inpatient hospitalization
Member of a target population?
NO
Medicaid eligible?
NO
YES
Directly enrolled provider for BASIC BENEFITS
YES
Community Support/Targeted Case Management Provider selected
Person-Centered Plan
including crisis plan
Diagnostic Assessment
Crisis services per crisis plan
Enhanced Benefits per Person-Centered Plan
Community Support, ACTT, or Targeted Case Management services
Adult MH services
Child MH services
Adult SA services
Child SA services
Adult DD services
Child DD services
CAP-MR/DD
ICF-MR
State operated facility services and other services
Natural& community supports
6/26/05
DMH/DD/SAS

As the system moves to develop or expand that response capability, it must use scarce resources in ways that are clinically effective and economically efficient. Establishing local crisis services is challenging to local organizations that must (1) meet current licensure requirements, (2) utilize billable service definitions, and (3) experience adequate demand for services to ensure stable organizations.

Strategic Development to Build Community Capacity

Key strategies for funding the development of community capacity include the downsizing of institutions and the transfer of institutional funding to the community. In order to successfully implement the downsizing plan for the psychiatric hospitals, the Division must work with the LMEs to develop sufficient community capacity to serve long-term residents of the hospitals. In addition, the Division is currently focused on transitioning residents to the community based on Olmstead plans.

In building community capacity, a key element is housing. Expanding the availability of decent, safe and affordable housing for persons with mental illness, developmental disabilities and/or substance use disorders is an area where it is necessary to target resources – staff time, technical expertise and investment.

Where individuals live is not an issue that can be addressed in isolation. It is directly related to the service system's capacity to provide the depth and range of community based services needed to support persons with disabilities in the community. The housing needs of mh/dd/sas consumers must be addressed with a range of housing/residential models. The pure supportive housing model with scattered sites and independent units with access to flexible support services tailored to individual needs and preferences is a recognized model of best practice.

Under current funding and reimbursement mechanisms few of these housing options are paid for through Medicaid or Division funding. Consequently, there are few traditional providers who are willing or able to assume the housing role. Assuring availability of community housing will require that there are an adequate number of residential providers and that the public mh/dd/sa service system expand its capacity to support its consumers in accessing and utilizing generic affordable housing resources.

Expanding housing opportunities requires an investment of time and relationship building: first in developing connections with housing providers, both public and private, so as to maximize access to existing resources, and then parlaying these connections into new development.

Housing resource development functions include:

- Collaborating with other disability and affordable housing advocates in efforts to assure that a fair share of public resources is targeted to extremely low income persons with disabilities. This would include participating in the area's consolidated planning process and representing the needs of mh/dd/sas consumers in continuum of care planning.
- Creating an inventory of currently available housing resources accessible to consumers, families and service providers, maintaining information on the unmet housing needs of persons served by the LME and developing strategies to address them.

- Developing a positive working relationship with local public housing authorities and HUD Section 8 administrating agencies to improve access and increase the supply of these resources.
- Developing low income housing tax credit, targeting plans and then supporting the continuing relationship with development management to assure that the units remain available to mh/dd/sas consumers and the tenants have access to appropriate services.
- Continuing administration of current Home Investment Partnership (HOME) or Housing and Urban Development (HUD) Homeless Assistance grants.
- Developing and maintaining an internal wait list for consumer referrals to housing resources that have referral relationships with the LME.
- Providing local liaisons to the development and operations of residential programs such as Oxford Houses and 122C Supervised Living.
- Engaging developers/providers as potential partners in housing development and developing a working knowledge of funding sources and how their regulations, income and population targeting, matching requirements, allowable development fees, etc. dictate how they can be combined.
- Providing education to consumers, families and service providers on accessing and maintaining affordable housing regarding the N.C. Landlord-Tenant and Fair Housing law and negotiating reasonable accommodations.

The LMEs should assure that housing needs are included within the community capacity building functions of the LME. The LME may choose to maintain this function within their administrative structure or contract with an existing or newly developed local community non-profit, including generic affordable housing providers and developers that serve the community at large. The activities of housing resource development will not be disability specific, but for the benefit of the target populations. Housing resource development staff will not be providing direct services to consumers but will work with community partners to develop a range of housing/residential capacity within the LME geographic area.

CAP-MR/DD Waiver Development

In July of 2004 a waiver development team was brought together for the specific purpose of designing a comprehensive waiver. The group consisted of individuals from teams across the Division, including Best Practice Team, Quality Management Team, State Operated Services section and Budget and Finance Team under the direction of the Deputy Director. In addition to the comprehensive waiver, the team was asked to begin work on the development of a self-directed services waiver that provides the opportunity for individuals with developmental disabilities to direct their own services and supports. A consultant with the Oregon Technical Assistance Corporation was brought in to provide technical assistance in the waiver development process. As a component of the waiver development process a stakeholder group was brought together to assist and provide feedback on waiver components.

In January 2005 the comprehensive waiver was submitted to CMS for approval. The goals of the waiver include:

- Promote the ability of individuals to live in communities of their choice.

- Promote movement of individuals from state developmental centers to the community through lifting of the individual fiscal limit.
- Provide for ease of service delivery through service definitions that are flexible and support the natural flow of a person's day.

Several components of the comprehensive waiver reflect changes in current processes. The comprehensive waiver will allow for final determination of ICF-MR level of care to be provided by clinical staff of Murdoch Center. Case management is no longer a component of the waiver but will be provided through Targeted Case Management as a part of the State Medicaid Plan.

Enhanced Benefits Package

The enhanced benefit service definition package is for persons with complicated service needs. The service philosophy includes expectations of "no wrong door," access to service 24/7/365, and service that begins with the first contact with a provider. For persons receiving enhanced benefits, initial treatment or service occurs at the same time that a Diagnostic Assessment is ordered and person-centered planning begins.

Changes that are reflected in the new or modified service definitions[12] in the enhanced benefit package include revised services that reflect evidence based best practices and emerging or promising practices. The design of services and the types of consumers who can benefit from each service are based on national models documented by research. All services include utilization review guidelines. Services are agency based with requirements for staffing and training and emphasis on taking the service to the consumer with delivery to the consumer in their normal daily life rather than being office based. Most of these services require the provider to be first responder to crises that occur for the consumers that they are serving; and, all of the enhanced benefit services require providers to gain national accreditation within three years.

Within the new and modified service package, diagnostic assessment and mobile crisis are available to all consumers. Services in this package that are available to consumers with mental health or substance abuse support needs include Community Support and Community Support Team. Assertive Community Treatment Team services are designed for adult consumers with extensive needs related to mental health and co-occurring mental health and substance abuse needs.

New services in the package that are specifically for children and youth who have mental health or substance abuse needs are Intensive In-Home and Multi-systemic Therapy. Community Support Service is also available for children and youth.

The new and modified enhanced benefit package includes services to meet many varied levels of substance abuse treatment needs of consumers. These include four levels of detoxification services, intensive outpatient treatment and comprehensive outpatient. With the implementation of the new services, North Carolina will offer, for the first time, a continuum of substance abuse services that meets every level of care outlined by the American Society of Addiction Medicine (ASAM).

[12] The new and revised Medicaid service definitions are available at: http://www.dhhs.state.nc.us/dma/propose.htm.

Transformation of Consumer and Family Participation in Reform

State and Local Consumer and Family Advisory Committees

The State Consumer and Family Advisory Committee (SCFAC) has been appointed and has begun its work. The SCFAC is a twenty-one member committee comprised of consumers and family members appointed by the Secretary of the Department of Health and Human Services. The SCFAC, in conjunction with the Division's Executive Leadership Team (ELT), provides input and conducts oversight of the Division's operations and efforts to accomplish the strategic outcomes of the State Plan. The committee has established their foundation documents to conduct business and received an orientation to the Division and its organizational structure. The SCFAC and the Division's ELT have established a communication protocol for the SCFAC and Division. The SCFAC established its priorities for the past year based on a review and prioritization of State Plan 2004 goals. Those priorities are to participate in 1) the development of State Plan 2005; 2) the development of provider reports or profiles; 3) advancing the opportunities for people with disabilities to influence the full range of the system from policy leadership to more discrete operations; 4) continuing research, dissemination and implementation of new best practices; and 5) continuing quality improvement efforts to assure model fidelity of supports and services.

The Division's Consumer Empowerment Team continues to work with local CFACs in each LME to increase their effectiveness and enhance the partnership relationship called for in the Reform. The Consumer Empowerment Team has worked in collaboration with other DMH/DD/SAS teams as well as community organizations to involve consumers, family members and advocates across the State in projects designed to enhance the level of their involvement in the state and local systems. In addition, they have worked collaboratively with other agencies and advocacy organizations to provide training to consumers and family members statewide related to initiatives designed to enhance the prevalence and effectiveness of consumer and family involvement in local and state systems change.

A CFAC resource manual is being developed offering examples of bylaws, methods for merging CFACs as area/county programs merge, newsletters, brochures, successful projects accomplished in partnership with LMEs, etc. This will be distributed to each CFAC and LME and will provide examples of CFAC documents and activities.

State and Local Advocacy and Customer Service

State Advocacy and Customer Service

At the State level, the Advocacy and Customer Service Section, responds to customer complaints, concerns, information requests and Medicaid recipients' appeals regarding services. All the information is tracked and published in quarterly reports that are posted to the Division website and distributed to stakeholders. The staff responds to issues brought to its attention by working closely with LME customer service offices and by responding to allegations of legal violations by conducting investigations in conjunction with appropriate State or local agencies. (See http://www.dhhs.state.nc.us/mhddsas/consumeradvocacy/index.htm).

Staff in this section also participates in Division policy development (a notable example of which is a state-wide complaint policy that all LMEs will implement) and helps to facilitate the Division's overall commitment to customer service that was established as a DHHS priority by Secretary Carmen Hooker Odom. The goal is for all Division staff throughout the State to be trained in customer service principles by December 2005.

LME Advocacy and Customer Service

At the local level, LMEs are developing customer service offices to respond to complaints, concerns, information requests and Medicaid recipient appeals. While each LME's office has unique features, all the offices will also have the following general functions: promoting public information to explain services and legal rights, supporting the CFACs, supporting the local human rights committees and conducting rights investigations to ensure that services are provided at the highest standards.

The Division's Customer Service and Community Rights Team works very closely with the LME local customer service coordinators to address individual issues and to build a coordinated state-wide system. They have worked with the North Carolina Council of Community Programs to develop a customer service curriculum that will be available to all LMEs to strengthen local customer service offices and prepare staff. The Customer Service and Community Rights Team also meets quarterly with local LME customer service coordinators and the North Carolina Council to discuss policies and strategies to better serve consumers and family members.

State Facilities Advocacy and Customer Service

The State Facilities Advocates Team continues to provide advocacy services to individuals who receive care and treatment in state operated facilities. This includes: training consumers/families and facility staff on the human rights of individuals residing in these facilities, conducting investigations into abuse/neglect and exploitation allegations, negotiating desired outcomes with facility administrators in areas identified as deficient or inadequate, reporting allegations to appropriate state and local agencies, being available to consumers and families for support/information/receipt of complaints and grievances and developing facility policies to uphold the consumers' rights and promote an enhanced quality of life. As time allows, advocates also contribute to treatment/behavior plan development, help to negotiate desirable aftercare arrangements when discharges occurred, support/participate in self-advocacy efforts of the consumers and other pro-active efforts.

Transformation of State Facilities

New Psychiatric Hospital

The Department of Health and Human Services (DHHS) has committed to the construction of a new regional psychiatric hospital in Butner, NC. The 432 bed facility will serve citizens needing inpatient psychiatric services in both the North and South Central Regions. The state hospitals currently serving the two central regions, Dorothea Dix Hospital in Raleigh and John Umstead Hospital in Butner, will continue to downsize such that remaining patients and admissions can be accommodated in the new facility and both of the older facilities will close.

Steering Committee

The new central region psychiatric hospital will be managed under the auspices of the Division and is designed to be "state of the art" in terms of design, infrastructure, automation, clinical treatment and support of patients. A steering committee, chaired by DMH/DD/SAS Division Director Mike Moseley, with membership from all of the key DHHS divisions and offices, is overseeing the activities associated with building and occupying the new hospital. These activities include the development of a communication plan, staffing issues, policy and procedure development, information technology design and implementation and the hiring of a director for the new facility.

The contract for construction was awarded in March and a ground-breaking ceremony was held on site in Butner on April 21, 2005, and hosted by Secretary Hooker Odom and Director Moseley. Construction is expected to be complete by late summer 2007.

Acute Care and Transformation of Alcohol and Drug Abuse Treatment Centers (ADATC)

The Division of MH/DD/SAS has been working to increase acute capacity at the Alcohol and Drug Abuse Treatment Centers (ADATCs) to divert involuntary substance abuse commitments from the State Psychiatric Hospitals. The change in mission for the ADATCs is to provide medically monitored detoxification, crisis stabilization, and short-term treatment to prepare adults with substance abuse problems for ongoing community based recovery services.

The programmatic changes at the three ADATC facilities will result in the creation of an additional 59 acute beds for a total of 84 crisis detox beds statewide and will decrease waiting lists to access short term treatment services at the ADATCs. The additional crisis detox capacity in the ADATCs is designed to reduce statewide admissions to the State Psychiatric hospitals by over 3,000 persons annually. The incorporation of best practice models into the ADATC programming result should eliminate waiting lists for short-term treatment and provide better transition into ongoing recovery efforts at the local level.

During state fiscal year 2004-2005 fifteen additional crisis detoxification beds became operational at R.J. Blackley ADATC for a total of 30 crisis detoxification beds to cover the Central Region of the State. The design drawings for the Crisis/Detox Unit at W.B. Jones ADATC were complete and submitted to the Department of Insurance. It is anticipated that the bid for construction will be let in May 2005 with a projected completion date of April 2006 resulting in twenty-four crisis detox beds for the Eastern Region. Design development for the Crisis/Detox Unit at J.F. Keith ADATC has been completed and drawings are being prepared for submission to the State Construction Office and the Department of Insurance for review. The anticipated date for the bid for construction is September 2005 with a projected completion date of June 2006 that will provide 30 crisis detox beds for the Western Region.

Strategic planning is in process with the ADATCs to introduce evidence-based treatment models and protocols for medically, behaviorally and diagnostically complex individuals who are unable to stabilize and initiate treatment in the community. Strategic planning workgroups are identifying training needs to enhance staff skills in evidence-based practices for the treatment and engagement of individuals with substance abuse and co-occurring disorders. Standardized

outcome tools to measure treatment effectiveness are under development. The American Society of Addiction Medicine's (ASAM) evidence-based treatment placement criteria and multidimensional risk matrix for co-occurring disorders are being piloted for use to determine the most appropriate and effective level of care for consumers.

Hospital Downsizing

Efforts have continued to downsize the four state operated psychiatric hospitals. The 2004 fiscal year plan targeted 172 beds by distributing $2,507,962 in trust fund monies to community mental health systems. The trust fund monies will be annualized in allocations to LMEs to $4,967,461 through funding reduced in the hospital budgets in accordance with their bed closures.

GlenCare Contract

A three-year pilot began in state fiscal year 2004-2005 to examine the need for and effectiveness of a specialized rate structure to support psychiatric patients in community skilled nursing facilities. The contract, with GlenCare in Warsaw, N.C., provides funding to support additional professional staffing in a specialized unit of a skilled nursing facility operated by Kornegay Health. DMH/DD/SAS and the Division of Medical Assistance (DMA) are jointly monitoring the efficacy and funding of the pilot. The goal is to demonstrate the value of an enhanced rate to support such specialized psychiatric skilled nursing units in community and thereby reduce the reliance on state operated facilities for care.

Special Care Facilities

The North Carolina Special Care Center (NCSCC), a skilled nursing facility located in Wilson, NC, underwent renovations to open an additional 20 bed unit that will operate using the Eden model of consumer support. The Eden model focuses on the nursing facility as a microcosm of community naturalizing activities to include plants, gardens, pets, and various social stimuli. The physical plant renovations were completed in February 2005. Additional staff will be hired and equipment purchased and/or moved from Cherry Hospital in anticipation of moving residents in by the end of the fiscal year. Renovations are also underway to remodel the 7th floor of NCSCC for a potential expansion of up to 47 beds for skilled nursing care.

Developmental Centers

North Carolina's developmental centers are continuing downsizing efforts by targeting those persons interested in receiving services in the community. The centers are working closely with families, LMEs and providers to accomplish this goal. Additionally, Caswell Center has assumed responsibility for being the developmental center in the eastern part of the state in keeping with the proposed three region plan. J. Iverson Riddle Center will be the center for the western region and Murdoch Center will be the center for the central region. O'Berry Center has developed an MR/MI program serving adults that opened May 1, 2005. Additional plans for the Center are currently being developed.

Request for Information (RFI)

Sixty four providers submitted proposals to the Division in response to a request for information (RFI) seeking providers interested in serving consumers moving from state operated developmental centers to communities. The proposals have been shared with the LMEs and Transition Coordinators at the three centers. Regional meetings have been held at each center to assist consumers and families in choosing a provider to best meet their needs. Providers must plan on a life long commitment to the consumers with supports and services that are person-centered.

Bed Day Allocation Plan

The State Operated Services (SOS) section of DMH/DD/SAS has worked with the area program/LMEs to manage the bed day allocation and utilization process for access to resources at the state psychiatric hospitals. The multi-year plan began by allocating days based on historical utilization and then reducing bed day availability to account for beds closed by downsizing.

Transformational Activities

Child Mental Health Plan Implementation

The Child Mental Health Plan[13] supports the foundation of reform by giving children and families a voice and focusing on collaborative and flexible services and supports delivered within the life environment of the child. The plan also addresses the issues and recommendations in the *Report of the Surgeon General on Mental Health* and the report of the *President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America*. These issues include building the science basis for treatment, overcoming stigma, improving public awareness of effective treatment, ensuring a qualified supply of providers, using evidence-based interventions, addressing cultural issues, improving access, and tailoring available resources to reduce barriers to effectiveness. The essential recommendations, which bridge the Surgeon General's Report and previously commissioned studies, include increasing community capacity, decreasing reliance on state operated services, establishing local accountability, establishing "bridge" funding, ensuring consistency and standardization of services state-wide and focusing on the primary consumer through child and family centered plans for supports and services.

The essential components of the plan include: decreasing fragmentation in service delivery, ensuring services are driven by the needs and preferences of children and families, elimination of disparities in mental health care through provision of culturally proficient services, early intervention and prevention and advancing the use of evidence-based practices and emerging best practices.

[13] DMH/DD/SAS with the State Collaborative for Children and Families, *Child Mental Health Plan*, September 2003.

Administration and Communication

An implementation team was named in August 2004 under the leadership of the Division's Chief of Clinical Policy. The team is composed of members from across the Division and consumer and family representatives.

Since March 2004, five quarterly newsletters have been produced and disseminated providing progress updates, highlighting youth and family involvement and best practice strategies that are cornerstones to the child plan. The Division's Child and Family web page has been redesigned and updated with current information, practice guidance and web links for easier access. (See http://www.dhhs.state.nc.us/mhddsas/childandfamily/index-new.htm).

Community Capacity and the Service Array

Progress has been made with the recent elimination of administrative and fiscal barriers in the delivery of services through the comprehensive treatment services program (CTSP) as described in the Division's Communications Bulletin #34 (August 2004). Implementation guidelines were disseminated to LMEs, providers, families and other stakeholders.

Trust funds were distributed through an LME request for application (RFA) process to develop and expand intensive in-home services statewide. These funds are being used to promote workforce competencies in best practice service components supported through the new proposed Medicaid service definition.

Transition from current Medicaid service array to the new and modified services has been addressed using multiple strategies. In addition to distributing trust funds to facilitate development of these community based services, training developed for initial orientation and in-depth practice for trainers of trainers has been developed and held January-June 2005. Training will continue to support the development of the full array during state fiscal year 2005-2006. Efforts are underway to help communities develop adequate crisis and acute services in communities across the state.

The Mental Health Commission is revising the rules for the residential spectrum of the service array in support of improved staffing ratios. The Division is working to align the service array across child serving agencies including the Division of Public Health, Division of Social Services and the Department of Juvenile Justice and Delinquency Prevention.

Quality Management

Outcome measures defined and included in the expansion of the NC Treatment Outcomes and Program Performance System (NC TOPPS) have been implemented in all area authorities/LMEs. Data will be collected on all children entering services in target populations. Preliminary reports will be reviewed and used to improve the system of care. Indicators will be evaluated for adjustments in the next state fiscal year 2005-2006.

Coordination and Collaboration with Child Serving Agencies

In developing a system of care, North Carolina has focused on planning efforts on several levels. Division representatives participate in the State Collaborative for Children and Families

that is comprised of the leaders of child serving agencies, families, advocates and other stakeholders. The State Collaborative provides the leadership support necessary to marshal resources and reduce barriers to promote implementation of local systems of care. Current collaborative efforts will continue with a focus on developing shared outcomes and indicators for measuring success across systems and in communities, joint training initiatives for workforce development and pursuing federal and foundation funding to improve school mental health services.

The locus of decision-making in a fully implemented system of care is the community through a local community collaborative. Decisions about the array of services and the organization of services are made in the community, reflecting its values, resources, needs and limitations. Agency program directors, decision-makers in community organizations, families and other community stakeholders are called on to participate in the system of care. They do this by supporting child and family teams to obtain needed resources, identifying and making decisions about service gaps, blending funds to maximize resources, identifying and addressing training needs to build local capacity and, ultimately, by holding each other accountable to meet the needs of their children and families.

In addition to working through the state and local collaboratives, the Division works closely with organizations and advocacy groups who have a primary interest in child mental health to increase family member involvement locally and on the state level. These groups include the state and local CFACs, the Mental Health Planning Council, the National Alliance for the Mentally Ill, the Mental Health Association, Families CAN, the NC Family Support Network, the Child Advocacy Institute, the Covenant for Children, Coalition 2001, North Carolina Families United and parent support groups in local communities.

Efforts to sustain existing interagency relationships with child-serving partners continue, including work with other divisions within DHHS. In addition, initiatives to strengthen school mental health services are well underway.

A state level task force drafted and disseminated *Saving Tomorrows Today: the NC Youth Suicide Prevention Task Force State Plan*. The task force will continue to support DHHS, Division of Public Health and DMH/DD/SAS in implementing the recommendations in communities statewide to prevent and reduce youth suicides.

Justice System Innovations

Division staff participated in the Council of State Governments' ReEntry Policy Council, a public/private partnership comprising practitioners, policymakers and advocates and funded in part by U.S. Departments of Justice, Labor, and Health and Human Services, to develop bipartisan recommendations that policymakers can use to improve the likelihood that adults released from prison or jail will avoid crime and become productive, healthy members of families and communities – which is essential to state and national efforts to increase public safety and manage public spending.[14]

[14] The comprehensive report, providing hundreds of policy recommendations, is available at www.reentrypolicy.org.

Treatment Accountability for Safer Communities (TASC) operates in all 100 NC counties in accordance with the Offender Management Model and the Department of Health and Human Services-Department of Correction Memorandum of Understanding, providing the link between the justice and treatment systems through assessment, treatment placement and care planning, coordination and management.

- Division staff and TASC are working with the Departments of Correction and Commerce and the Community College System to implement NC's Offender ReEntry Initiative: Going Home, funded by the U.S. Department of Justice. The purpose of the Going Home initiative is to develop a comprehensive offender reentry strategy that ensures public safety by addressing supervision and service needs of offenders returning from prison to local communities. Consistent with mental health reform, this initiative seeks to create sustainable transition and reentry processes that engage all aspects of the community to support offender reintegration.
- Division staff and TASC worked with the Division of Community Corrections and the Division of Alcoholism and Chemical Dependency Programs to successfully implement HB 352. This legislation provides for assessment prior to placing offenders in the residential level of care (DART-Cherry) offered by the Department of Correction, reducing lengthy waiting lists and assuring appropriate use of limited resources.

Community Education and Workforce Development

North Carolina has developed a strategic workforce development plan.[15] The document describes the initial and multi-year goals and strategies for implementing a statewide system of planning and responding to education and training needs in North Carolina's public mental health, developmental disabilities and substance abuse system reform. The Statewide framework for workforce development will include the following three elements:

- A state network for workforce development that will provide long-term policy and planning advice to the state regarding a strategic and coordinated system for workforce development.
- A system of local/regional networks to implement a statewide framework for workforce planning and development.
- A learning portal web site that will contain information about approved education and training programs, sponsor online courses and increase workforce access to training, when, where and how it is needed.

Statewide Network – Committee was formed in October 2004. Membership represents a broad spectrum of education and training providers and stakeholders in the mh/dd/sas system. The committee is determining ways for appropriate data to be gathered and used to make recommendations about long-term education and training of personnel.

[15] The Workforce Development Plan was published in July 2004 as the Division's Communication Bulletin #22 and can be viewed at: http://www.dhhs.state.nc.us/mhddsa/announce/index.htm.

Local Networks – Eleven LMEs have volunteered to facilitate coordination of personnel training and education in their geographic areas. They are in the midst of organizing themselves to work in a coordinated way to address education and training issues.

Learning Portal – Work on this has been postponed until more is known about state-level plans to implement a learning management system.

Training for Mental Health Service and Local Management Entities

As part of the annual plan for workforce development, the Division was a sponsor and a co-sponsor of training through contracts with the North Carolina Council for Community Program's LME Academy and Leadership Forums, through the North Carolina Area Health Education System (AHEC) and through colleges and universities. An annual statewide case management conference was held in November 2004 with over 600 people attending. The annual best practices in developmental disabilities conference was held in April 2005 with over 700 people attending. The annual consumer empowerment conference accommodated approximately 300 people. Mental Health Block Grant funding enabled East Carolina University, School of Social Work to offer a specialty track to prepare Masters of Social Work students to provide mental health services to consumers who are deaf or hard of hearing. In addition, funding was used to contract with North Carolina branch of the National Alliance for the Mentally Ill (NAMI-NC) to provide their Family to Family Education Program and with the NC Mental Health Consumers' Organization to provide Wellness Recovery Action Plan training for consumers.

As the training focus turned to needs around new definitions of services, the Division began development of the N.C. Learning Community. The Learning Community would be made up of entities providing training in service definitions, person-centered planning (PCP) and evidence based practices endorsed by the Division. At present, the N.C. Council of Community Programs, The Behavioral Healthcare Resource Program of the UNC-CH School of Social Work and the UNC-CH Developmental Disabilities Training Institute provide endorsed training. The NC Evidence-Based Practices Center is endorsed to provide training in Assertive Community Treatment Teams and Support Employment – both related to adults with mental illness. The Division also launched a project to prepare experienced workers to provide training on the Division's behalf. Over 100 instructors have been approved. The Division directly provided three conferences on service definitions in early 2005 with 1500 people attending. To explain the new service definitions to consumers, two statewide videoconferences were also held. The Division sponsored over 75 person-centered planning and service definition training events that reached 1577 people. Over 70 PCP trainers were trained or re-trained. Thirty-five events, most of which involved more than one day, related to administrative matters were provided for approximately 2600 people.

Information Technology/Services

Implementation of mental health reform requires that the Division have access to accurate and relevant information that can be presented in a user-friendly manner. The need to collect and analyze management and financial data for planning, establishing benchmarks, measuring individual and systems outcomes and information decision making has been identified. To support the work of the Division, LMEs and state facilities, the Division's information technology efforts have centered on the development of the Integrated Payment and Reporting System (IPRS), the Medicaid Management Information System (MMIS), in addition to compliance with HIPAA requirements. The status of these information technology initiatives is outlined below.

Integrated Payment and Reporting System (IPRS)

The Division initiated implementation of the Integrated Payment and Reporting System (IPRS) in 2002. This system replaced the outdated Pioneer system and four other program specific billing systems. The IPRS is designed to be a HIPAA compliant, multi-payer system integrated with the state's Medicaid payment system, providing providers of services the ability to send one bill to the state for payment of state or federal monies. Statewide implementation was completed on November 30, 2003 and has moved to production status. This system will be replaced with the new MMIS+ system NCLeads.

Clinical Care and Client Management System (CCCMS)

The State's objective is to provide a seamless, cohesive, comprehensive Behavioral Health Care Management System built upon a series of incrementally implemented modules. It is our intent to use HL7 compliant transactions through an Interface Engine to communicate with foreign Admission, Discharge, Transfer, Billing, and potentially other modules. The facilities currently have a few different automated solutions in place for Food and Nutrition and Dental Tracking. In the future we intend to standardize these automated functions across facilities and plan to continue the HL7 and other standardized information exchange models where appropriate. The MRCs have a few different solutions used for habilitation planning and tracking. Psychiatric Hospital and ADATC person-centered planning and Psychiatric Hospital Mall Management efforts to automate shared solutions are currently underway. This system is to link both state facility and community programs in the support of patient Care.

Medicaid Management Information System (MMIS)

The Medicaid Management Information System (MMIS) is the state's Medicaid reimbursement and decision support system. This system was recently upgraded to include the multi-payer functionality of the IPRS for reimbursement of state and federal block grant dollars on state approved mental health, developmental disabilities, and substance abuse services. In 2003 the state developed and posted an RFP to replace the current system focusing on ease of use and maintenance, flexibility, modern technology and cost reduction. A vendor has been selected. On June 1, 2004, a two-year effort began to modify and implement the replacement system NCLeads. Current schedule calls for the first Medicaid check write using the new system to occur in the first week of July 2006.

Health Insurance Portability and Accountability Act (HIPPA)

Data Infrastructure - As a participant in the Substance Abuse and Mental Health Services Administration's Data Infrastructure Grant, the North Carolina Division of Mental Health/Developmental Disabilities and Substance Abuse Services developed a comprehensive decision support system. This system will be based in part on the federal Mental Health Statistics Improvement Project's Decision Support 2000+, a new mental health information system model. Beginning in July 1999, the Division has been developing and building a server based production database (Client Data Warehouse) to process, clean and store the Division's clinical, demographic, outcome, eligibility and service/claims data. In 2001 the Division entered into a partnership with other Department of Health and Human Services agencies to participate in a departmental-level Decision Support Information System. Data from the Division's Client Data Warehouse is being selectively migrated to the new Decision Support Information System that is web based.

Chapter 4. Person-Centered Planning

Person-centered planning is fundamental to reform within the mental health, developmental disabilities, and substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning, and treatment, service and support options. The individual with a disability and/or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

Person-centered, family-focused methods are used to identify life outcomes and determine strategies for achieving the outcomes. For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others as identified by the individual (i.e. employers, teachers, faith leaders, etc.). These individuals can be essential to the planning process and help drive its success. The plan is more likely to be strengths-based and recovery oriented when planning is undertaken in true partnership with the individual and families and when agencies, policy makers and funding sources value and monitor outcomes such as individual and family satisfaction, community integration, needs met, quality of life and achievement of individualized goals.

Person-centered planning uses a blend of paid and unpaid, natural and public specialty resources uniquely tailored to the individual/family needs and desires. Publicly funded specialty services are often critical for treatment and habilitation of individuals with disabilities; however, some needs can best be met by communities and naturally occurring supports. Therefore it is important for the person-centered planning process to explore and utilize both paid and unpaid sources of support.

The key values and principles that are the foundation of person-centered planning are:

1. Person-centered planning builds on the individual's/family's strengths, gifts, skills, and contributions.
2. Person-centered planning supports consumer empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations.
3. Person-centered planning is a framework for providing services, treatment and supports that meet the individual's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person-centered planning supports a fair and equitable distribution of system resources.
5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community, as they choose.
6. Person-centered planning sees individuals in the context of their culture, ethnicity, religion and gender. All the elements that compose a person's individuality are acknowledged and valued in the planning process.

7. Person-centered planning supports mutually respectful and partnering relationships between providers/professionals and individuals/families, acknowledging the legitimate contributions of all parties.

One of the essential elements of each person-centered plan is a crisis plan. Information is included about proactive steps to prevent crises from occurring such as identifying early warning signals of an impending crisis and the types of situations that may trigger a crisis. The plan also includes information about what process or procedure will be followed when a crisis event or emergency situation occurs, such as whom to call, what actions to take with the individual in crisis, what crisis services or hospitals should be used.

Person-centered planning guidelines have been distributed as a Division Communication Bulletin # 034 (3/21/05) available on the Division's website.[16] These guidelines contain the underlying values and principles, the essential elements of person-centered planning, the required documentation elements, and indicators to demonstrate that person-centered planning has occurred.

[16] See http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.

Chapter 5. Quality Management

Quality management's overarching purpose in the NC MH/DD/SAS system is to support achievement of the goals of reform, namely that:

- Individuals benefit from the services they receive from the public mh/dd/sas system.
- Public resources are used effectively to sustain and improve those benefits.
- All participants in the mh/dd/sa service system are accountable for their actions and empowered to improve the system.

It includes mechanisms and activities that promote adherence to basic standards and improvements over time.

To be effective, quality management requires integrated structures and processes that permeate all levels of every organization within the service system and work toward the objectives of:

- Safeguarding the health, safety, and rights of consumers.
- Supporting the achievement of desired outcomes and satisfaction for consumers.
- Ensuring fair access to services, especially for those most in need.
- Ensuring the integrity, effectiveness, and continuous improvement of services.
- Ensuring compliance with basic state and federal requirements and standards.
- Evaluating the system reform implementation process.

To achieve these objectives, North Carolina's mh/dd/sas quality management system will employ the following strategies:

- Adoption of a balanced interactive approach to assuring and improving quality.
- Involvement of all stakeholders in quality management processes.
- Involvement of SCFAC in quality management activities including tracking and reporting on outcome measures and performance indicators.
- Training and education to support quality management efforts.
- Use of local resources to identify and remedy problems quickly.
- Adherence to statewide standards for service quality.
- Development and use of fair and objective indicators of performance to hold all levels of the system accountable.
- Collection and analysis of standardized information from multiple sources within the state service system to identify and respond to achievements, problems, concerns, and opportunities for improvement.
- Ongoing evaluation of the effectiveness of the quality management system.

Principles of Quality Management

Effective quality management depends on continuing, honest analysis of current data and the goals of the system. That can only be accomplished by listening to the perspectives of all participants in the system and heeding their views on how to make things better. The N.C. mh/dd/sas quality management system will adhere to the following principles:

- Commitment of all participants to achieving the mission and vision of the State Plan.
- Commitment from leaders at all levels of the system to a philosophy of continuous quality improvement that emphasizes transparency and involvement of participants at all levels of organizations within the system to effect ongoing progress toward stated goals.
- A definition of quality centered on the needs and desires of person served by the system.
- Respect for the views of consumers, families, service providers, and public agency staff and support for them to take ownership and responsibility for the quality of the service system.
- A culture of collaborative learning that encourages all participants in the system to set goals, take reasonable risks, learn from mistakes, celebrate achievements, and share what is learned.
- Accountability based on fair, valid measures and standards of performance and coupled with support for improvement.
- Well coordinated, effective quality management structures and processes that are inclusive, creative, solution-focused, regular, action-oriented, and driven by common sense.
- Coordination and collaboration among local and state governmental agencies and community organizations serving people with disabilities.
- Adequate commitment of resources for quality management.

These principles will be supported by a quality management system with the following characteristics:

- A clearly written, easily understandable plan that articulates the purpose, processes and expectations of the QM system, establishes clear roles and responsibilities for all stakeholders, and is updated regularly.
- Consumers/family members, including Consumer and Family Advisory Committees and the State Consumer and Family Advisory Committee, actively involved in the design and operations of the quality management system.
- An emphasis on quality improvement activities, supported by quality assurance activities that ensure the safety of individuals and compliance with basic standards of service quality.
- Structures and processes that foster a culture of respect and mutual learning, with education and technical assistance to reinforce that culture.
- Mechanisms for evaluating outcomes, processes, and structure that emphasize attainment of desired individual outcomes through fidelity to best practice models of service.
- Collection of data that is standardized, non-redundant, efficient, and actively used to promote progress toward goals.
- Mechanisms for translating knowledge gained through quality management processes into changes in practice that improve services, individual outcomes, and the health and safety of people served.
- Ongoing self-examination of the quality management system itself to support improvements in the effectiveness of QM structures and processes.

Quality Management Overview

There are two basic components of a comprehensive quality management (QM) system:

- **Quality Assurance** (QA) focuses on *evaluation of compliance with basic standards of quality*, which may be internally or externally imposed. In addition to an organization's internal self-monitoring activities, QA includes monitoring by oversight agencies to ensure that the organization's efforts comply with externally-imposed requirements, as set forth in state and federal statutes, rules, and regulations, accreditation standards, and third party payer contracts. QA can involve on-site observation, review of documents and other data, and investigation of specific concerns. QA activities can result in technical assistance, corrective action requirements, or serious penalties to ensure adequate response to problems.

- **Quality Improvement** (QI) focuses on *proactive self-evaluation and improvement efforts* to support continuous progress toward meeting *optimal goals* as determined by the needs of consumers, families and stakeholders and the mission and vision of the State Plan. QI relies on a culture of collaboration, mutual learning, and shared responsibility among all participants. QI uses systems thinking, input from internal and external customers, analysis of data from a variety of sources, and ongoing self-evaluation to identify past trends, predict future ones, and find ways to improve the service system over time. QI activities can result in improvement projects, changes to an organization's practices, or revisions to the organization's quality improvement plan.

Only through a philosophy that balances QA activities with ongoing QI processes can the Division achieve the goals of reform and create a system that is truly responsive to consumers. The reform initiative has laid the groundwork for shifting the focus from a historical emphasis on QA to a more balanced approach to QM. Essential QA monitoring activities will continue to the extent that they directly serve the goal of ensuring the viability of the system, safeguarding consumers and improving the quality of services. Ongoing QI activities will be developed and coordinated across all levels of the state to guide policy and practice.

Roles and Responsibilities

One of the salient principles of a quality improvement philosophy is that improving quality is everyone's responsibility, not just the state oversight agency or the upper-level management of organizations in the service system. Thus, an effective QM system depends on a commitment to self-improvement that starts with each individual consumer and extends to every person at every level of the system. Applying this principle means that an effective QM system must be integrated within organizations and coordinated across organizations. Internally, organizations must find ways to support staff to improve their skills and work processes, share ideas and concerns, and participate in quality oversight and improvement processes. Externally, organizations must work as partners in identifying and resolving those issues that impact the local service community or statewide service system and support other organizations in their efforts to improve.

There are basic QM responsibilities that apply to the internal operations of all organizations in the service system. These include:

- Dedication of staff and other needed resources to manage quality initiatives.
- Effective technological systems to facilitate the collection, analysis, and sharing of information.
- Training and supervision of staff.
- Monitoring of adherence to internal policies and procedures.
- Mechanisms for receiving and responding to feedback from customers.
- Mechanisms to ensure protection of consumers' health, safety, and rights.
- Mechanisms for communicating concerns, changes, and achievements effectively.
- Plans and resources for responding to crises quickly and effectively.
- Responsiveness to requests from oversight agencies.
- Quality improvement plans, structures, and processes that guide how the agency conducts ongoing self-evaluation and improvement activities.

Participants at each level of the system also have specific roles and responsibilities for making a QM system work. These are described below.

Consumers and Family Member Responsibilities

Consumers and family members act as the primary barometers of the quality of the system. They contribute to quality by:

- Actively choosing their providers.
- Actively participating in setting goals and strategies for their person centered plans.
- Advocating for services that meet their needs and sharing information about their concerns.
- Participating in efforts to evaluate their life outcomes and experiences with the service system.

To be effective participants in the improvement of quality, consumers and family members must have valid information on providers, clear, accessible routes of communication, knowledge of their rights, and education in effective self-advocacy techniques and quality management processes.

Consumer and Family Advisory Committees (CFACs)

The QM system accesses the collective voices of consumers and family members through each LME's local Consumer and Family Advisory Committee (CFAC) and the State-CFAC. In addition to providing consumer input into policy decisions, the CFACs participate in the QM system by:

- Identifying unmet service needs, emerging problems, and other concerns.
- Participating in the collection of information on consumer experiences and system performance through mystery shopper programs, interviewing of other consumers, and providing input into valid ways to collect data on individual outcomes and satisfaction with service quality.
- Reviewing data on trends in system performance, consumer experiences, and life outcomes and making recommendations for improvement.

- Providing representatives to local and state quality improvement committees.
- Facilitating consumer and family understanding of and participation in quality improvement projects at the provider, LME, community and state level.
- Self-examination and improvement activities to increase the effectiveness of the CFACs.

Provider Responsibilities

Service providers are the first avenue for ensuring the quality of services. Providers lay the foundation for effective services through the achievement and maintenance of:

- State licensure requirements.
- Endorsement by the LME and enrollment by the state for provision of specific services.
- Accreditation as a service provider by a national accrediting body recognized by North Carolina.
- Collection of information on consumer service needs, experiences, and outcomes
- Protection on client rights

LME Responsibilities

The Local Management Entities (LMEs) are responsible for local oversight of services provided in the counties they serve. The foundation for the LMEs' quality management functions are established by:

- The quality management section of each LME's approved local business plan.
- Achievement and maintenance of accreditation as a managed behavioral health organization by a national accrediting body recognized by North Carolina.

QM activities specific to LMEs include:

- Service authorization and management
- Provider endorsement and oversight
- Coordination of area-wide data collection and quality improvement activities

NC Council of Community Programs

The NC Council of Community Programs (NCCCP) is an association of LMEs that works closely with DMHDDSAS to coordinate LME input into statewide policy decisions. Many LMEs contract with the NCCCP to conduct provider certification reviews and/or local monitoring of providers and to coordinate sharing of information on the results among LMEs.

Responsibilities of State Facilities

Each of the state operated facilities has responsibility for quality management of its operations, including:

- Adherence to a quality management plan and processes.
- Achievement and maintenance of accreditation by a national accrediting body recognized by North Carolina.

While the process and products of these efforts vary by facility type (i.e. psychiatric hospital, mental retardation center, or alcohol and drug addiction treatment center), there are quality indicators that are consistent across all services and populations.

DMHDDSAS Central Office Responsibilities

The Division has the primary responsibility for ensuring that our state's overall service system protects the health, welfare and rights of consumers and achieves the goals of the State Plan, including development of a comprehensive QM system. The foundations for the Central Office quality management functions are established by:

- The North Carolina state mental health reform legislation and the annual state plan.
- The requirements of federal and state statutes, rules, and regulations
- Federal performance requirements and guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Medicare and Medicaid Services (CMS).

The system-wide QM responsibilities of the Division include:

- Setting goals, policies, and the strategic plan for the system
- Operationalizing and implementing the state's strategic plan.
- Overseeing performance of the service system
- Tracking progress toward State Plan goals and evaluating the impact of state reform.
- Managing statewide data systems and disseminating information on system performance and consumer outcomes.
- Coordinating consumer involvement and responding to consumer concerns and inquiries

Responsibilities of the N.C. Department of Health and Human Services

The Department is responsible for setting policy direction and overseeing the fiscal and programmatic operations of the Division. It coordinates the development of departmental goals and performance requirements, conducts regular reviews of fiscal and contractual obligations, and responds to feedback from system stakeholders. The Division works with sister agencies within the Department to:

- Manage enrollment of qualified providers and utilization of Medicaid funds
- License and oversee mh/dd/sa service providers
- Oversee child and adult protective services and investigate allegations of abuse, neglect, and exploitation
- Collect and analyze data on births, deaths, and a variety of health issues for North Carolinians, including the need for mh/dd/sa services.
- Manage data that cuts across different agencies within the Department.

Statewide Coordination of Quality Management

Coordination of QM activities across local and state levels and across agencies that serve people with disabilities is necessary to ensure successful progress toward the individual and system goals of State Reform.

Local Coordination

The LMEs act as the hubs of local QM systems, providing leadership, coordination, and support for QM activities across provider agencies and other community resources through the following means:

- Building community awareness and understanding of QM processes, local achievements, and areas for improvement
- Educating consumers, providers, and other community members in the philosophy of quality improvement and how to use information on trends to evaluate progress
- Providing leadership and active participation in local community collaboratives that bring together community agencies and groups to coordinate and improve services to local residents
- Developing, staffing, and actively participating in a Local Quality Council that brings together representatives from the local CFAC, provider agencies, the LME, state-operated facilities, and other public agencies and community organizations that serve local people with disabilities to address community-wide issues of service availability, coordination, and quality.
- Partnering with the local CFAC in identifying, developing and assessing quality management activities across the provider and community system.

MH/DD/SAS System-wide Coordination

DMH/DD/SAS is responsible for providing the direction, coordination, support and oversight of the statewide quality management system. The Division brings together QM activities from local communities, state-operated facilities, and the Central Office to ensure that issues and concerns from across the state are used to identify and address statewide issues of quality. The Division is responsible for:

- Building statewide awareness and understanding of QM processes, achievements, and areas for improvement.
- Educating consumers, LMEs, and the public in the philosophy and techniques of quality improvement.
- Providing leadership and active participation in state collaborative efforts that bring together public agencies and groups to coordinate and improve services to NC residents.
- Developing, staffing, and actively participating in a State MH/DD/SAS Quality Council that brings together representatives from the state CFAC, provider agencies, LMEs, state-operated facilities, and other public agencies and statewide organizations that serve people with disabilities to address statewide issues of service availability, coordination, and quality.
- Involving the SCFAC in the oversight of the statewide quality management system.

The NC Council of Community Programs hosts several quarterly forums that bring LME staff together to discuss means of implementing DMHDDSAS policy decisions. The QI Forum, Consumer Rights Forum and Provider Relationship Leadership Forum are instrumental in facilitating QM tasks by creating a network of state and local staff across the state that share solutions to common problems and support development of a statewide culture of quality improvement.

Statewide Cross-Agency Coordination

Mechanisms for increasing communication, collaboration, and coordination across divisions of the NC DHHS and other state agencies that serve people with disabilities are essential for development of an effective Quality Management system. The Division works with sister agencies and Department staff to provide guidance, coordination and support for inter-agency collaboration through the following means:

- Coordinating local and state-level monitoring activities, investigations, and actions to correct problems.
- Coordinating requirements for local reporting and data collection across agencies.
- Coordinating sharing of statewide information across service agencies.
- Setting priorities and providing support for inter-agency initiatives.
- Supporting development of inter-agency collaboration at the state and local levels.
- Providing leadership and active participation in state collaborative efforts that bring together public agencies and groups to coordinate and improve services to NC residents.

Current Statewide QM Initiatives

The NC MH/DD/SAS quality management system is being developed, first, by enhancing and revising existing Quality Assurance and Quality Improvement activities and, second, by expanding and better coordinating QI initiatives. The Division has adopted the Quality Framework for Home and Community-Based Services, developed by the federal Center for Medicaid and Medicare Services (CMS), to guide QM policies and practices for the NC MH/DD/SA service system. The following description of QM components that are currently in place is organized using the QM functions that comprise this framework.

Design

The design function refers to strategies for building quality assurance and quality improvement into the conception and design of the system.

Quality management is being designed into the NC system through:

- Clearly articulated mission, vision, values, and principles for the service system.
- Consumer involvement in system design, service planning and delivery, and oversight.
- Locally accountable and responsive service delivery systems.

- Fair, objective measures and standards against which performance is measured.
- Collection, synthesis, and sharing of performance information.

The North Carolina system reform design lays the structural groundwork for building an effective QM strategy. Increased dedication of local and state resources to technology, data analysis, and oversight will support evaluating and improving the impact of the service system on consumers' lives. Out of necessity, detailed plans and methods are being developed as reform plans are being implemented. The following components of reform designed to build quality management into the system are currently in place or being put in place in state fiscal year 2005-2006:

Service Quality

The foundations for ensuring quality of services are achieved through adherence to criteria for fair access to timely, appropriate services from qualified, effective providers.

Service Access and Management

LME accreditation: LMEs are responsible for building and managing a clinically-effective and cost-effective array of services for their communities, ensuring rapid and effective response to individual and area-wide crisis situations, and coordinating community improvement initiatives. The LMEs, which have been nationally accredited by the Council on Accreditation as service providers in the past, will now become accredited as local system managers. The Division recognizes five national agencies that LMEs can work with to satisfy this requirement: the Council on Accreditation (COA), the National Council on Quality Assurance (NCQA), the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), CARF, and URAC. One LME has already achieved full accreditation by NCQA and the others are currently in the process of selecting an accrediting body and working toward accreditation. Details of accreditation policies can be found in Communication Bulletin #36.

LME Performance Contracts: The Department oversees the management and provision of local services through a Performance Contract with each LME that is renewed regularly. The contract includes statewide requirements reflecting the LME responsibilities for:

- General administration and governance.
- Access, triage and referral.
- Service management.
- Provider relations and support.
- Customer services and consumer rights.
- Quality management and outcomes evaluation.
- Business management and accounting.
- Information management, analysis and reporting.

The contract includes statewide performance measures and standards in each functional area that are analyzed and reported by the Division each quarter to the Department, LMEs, county commissioners, State and local CFACs, and the public for use in evaluating and improving local

performance. The performance standards are reviewed annually and revised to support incremental improvements in the quality of the local system over time.

Crisis Planning and Response: Ensuring the safety and security of individuals receiving services requires each LME to plan for and respond to emergency situations of individual consumers. LMEs ensure training of staff in prevention and alternatives to use of restrictive behavioral interventions, authorize crisis plans for individuals as part of PCPs, and, when necessary, provide crisis services within appropriate timeframes (two hours for emergent situations and forty-eight hours for urgent situations).

Management of Institutional Services: Each of the state operated facilities is required to engage in a quality management process either by virtue of their accreditation/certification or by Division requirements. While the process and products of these efforts vary by facility type (i.e. psychiatric hospital, mental retardation center, or alcohol and drug addiction treatment center), there are quality indicators that are consistent across all services and populations. The Division is preparing a systems quality audit process, beginning with the state operated psychiatric hospitals that will identify opportunities for uniformity and consistency while continuing to respect the local needs of the individual facilities.

Dedicated QM Staff and Resources: The reform has provided the resources for all levels of the system to designate staff to be responsible for the management of quality assurance and improvement activities. In addition, the Division is developing statewide technological systems to increase the efficiencies of processing service claims and payments, tracking consumer outcomes and experiences, and evaluating system performance.

Provider Qualifications

Licensure and Certification: Providers of most residential, day, and substance abuse services are licensed by the Division of Facility Services or the Division of Social Services. Rules require written policies for management, admission and discharge criteria, record management, quality assurance and improvement activities, medication administration, protection of consumer safety and rights, and other areas of consumer services. Rules also include requirements for facility design and equipment, staff qualifications, supervision, and training.

Providers that are not required to be licensed must be certified by LMEs and DMH/DD/SAS before they can be authorized to receive Medicaid or state funding. The certification process holds providers to similar requirements as licensed providers.

See also http://www.dhhs.state.nc.us/mhddsas/announce/commbulletins/commbulletin-037provider4-22-05memoall.pdf.

Endorsement of Services: Beginning in state fiscal year 2005-2006 providers of Medicaid services must be endorsed by an LME for each service provided at a particular site and sign a Memorandum of Agreement, which includes a Business Associate or Qualified Service Organization Agreement, before they can be enrolled to receive payment directly from DMA. Standardized criteria and checklists for evaluating the provider's capabilities to provide the service and fidelity to best-practice models are currently being designed for implementation in

July 2005. After being endorsed by an LME, the Division and DMA make a final determination of a provider's enrollment status for Medicaid payments.

Providers that do not enroll directly with Medicaid work under contract with an LME to provide publicly-funded services. The contract requirements hold providers to similar requirements as the endorsement process.

National Accreditation for Service Provision: The new service definitions that go into effect in state fiscal year 2005-2006 require providers to become nationally accredited within three years of enrollment as a provider. The Division recognizes four national accrediting bodies for providers to choose among to satisfy this requirement: the Council on Accreditation, the Council on Quality and Leadership, the Joint Commission for Accreditation of Healthcare Organizations, and CARF Communication Bulletin #36 gives details on the accreditation policy.

Individual Service Planning and Oversight

Person-Centered Planning and Individual Outcomes: The person-centered planning process for each consumer entails setting personal goals in a variety of life areas, developing strategies for achieving them, and refining goals as needed. Person-centered, family-focused methods are used to identify life outcomes and determine strategies for achieving the outcomes. In addition to the use of standardized tools that are appropriate for assessing service needs for the individual's disabilities, the Division requires providers to use the Global Assessment of Functioning (GAF), Child and Adolescent Functional Assessment Scale (CAFAS), American Substance Abuse Measures criteria (ASAM), and NC SNAP to assess the appropriate service array and level of support needed for an individual.

Beginning in July 2005, the NC TOPPS system (described later in this chapter) will facilitate the development of person-centered plans through the tracking of information about each mental health and substance abuse consumer's needs and preferences, clinical functioning, quality of life, and use of services.

Service Authorization and Review: LMEs are responsible for authorizing person-centered plans and reviewing service utilization for clinical appropriateness.

Disaster Planning and Response: The Division has a Disaster Preparedness, Response, and Recovery Plan in place to protect and support individuals in the event of natural disasters or other public emergencies. The plan establishes the roles that local and state agencies will play prior to, during, and in the aftermath of disasters to ensure the provision of counseling services to disaster victims; evacuate and relocate mh/dd/sas consumers when necessary; and facilitate the provision of stress management services to disaster responders. The statewide Disaster Plan serves as a guideline for LMEs to develop local disaster plans to educate residents about disaster services, prepare for community disasters, and coordinate response efforts with state and local agencies.

Discovery

The discovery function of quality management refers to the gathering of information to make certain that people, processes, and products are meeting basic requirements of quality and to

evaluate progress toward goals. Discovery processes use information from multiple sources to analyze system performance and identify concerns and opportunities for improvement.

The North Carolina system reform effort includes development of statewide, standardized measures and data systems for tracking, understanding, and responding to trends. While building on historical methods of on-site monitoring and review of administrative data, system reform moves the state toward more consumer-friendly methods of collecting information and increasingly sophisticated technological resources to improve analysis and sharing of data on the above domains.

Consumer Safeguards & Rights Protection

Incident Response

Administrative rules require all service providers to participate in a Division-coordinated system for responding to and reporting adverse events involving consumers. The incident system includes deaths, injuries, use of restrictive behavioral interventions, medication errors, allegations of abuse or neglect, and consumer behavior issues.

Incidents are divided into three levels of severity, which determine the intensity and breadth of the response:

- Level I includes incidents that have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed. Level I incidents are handled internally within the provider agency.
- Level II includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions. Level II incidents are handled internally by the provider agency and reported to the LME, which ensures appropriate response by the provider.
- Level III includes incidents of death or permanent impairment of a consumer or caused by a consumer. In addition to the response and reporting required for other incidents, providers must convene a team within 24 hours to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and LME of steps taken.

Provider agencies, LMEs, and the Division review individual incidents to safeguard consumers, correct immediate problems, and minimize the reoccurrence of similar incidents. They also analyze aggregate information on incidents quarterly to identify and respond to trends as part of quality improvement activities.

Complaints

Providers, LMEs and the Division assure that individuals receive support to exercise their rights and voice complaints about services by having procedures for receiving and responding to complaints. The LME is the local hub for informing consumers about their rights and receiving complaints about service provision. LMEs seek to resolve complaints between consumers and providers informally whenever possible, before activating the formal complaint process.

The Division also receives, coordinates response to, and investigates complaints from consumers and the public. Where possible, the Division works with the LME to resolve complaints locally.

Providers, LMEs and the Division track and analyze trends in complaints for use in quality improvement processes. LMEs will begin reporting trend information on complaints to the Division in state fiscal year 2005-06 to facilitate identification of statewide issues and opportunities for improvement.

Monitoring of Services

Service Utilization and Costs

Utilization management (the regulation of service provision in relation to the capacity of the system and needs of consumers) ensures that services are necessary, appropriate, and cost effective through pre-authorization of services for individuals, evaluation of the need for continued services, and extended authorization as determined by the evaluation.

The initial authorization of enhanced services is conducted by the LME, as part of their approval of person-centered plans.

The LME conducts periodic reviews of service utilization, through retrospective or concurrent study of service delivery quality, record keeping adequacy, and cross checking on previous utilization management activities affecting individual consumers.

The LME also monitors the overall cost of services to consumers in its catchment area to ensure cost-effectiveness. LME's establish internal reporting mechanisms to track use of funds and the Division monitors the status of the LME's virtual budgets using information from the Medicaid Paid Claims Information System and the state Integrated Payment and Reporting System. The Division produces a monthly report for LMEs that describes the services paid for each consumer, the number of units billed, the cost and the number of consumers receiving each service. These data facilitate the monitoring of service utilization and costs and the early identification of potential areas of concern.

The Division and DMA jointly conduct annual Medicaid Compliance Audits to ensure that requirements for staff qualifications, service authorizations, service plans, service documentation, and billing protocols are met. The audit is conducted using an audit tool created jointly by the two agencies. Regular analysis of audit results allows for revision to the tools to address areas of concern and raise the standards of financial accountability and service quality. The annual sample of agencies to be audited takes into consideration compliance from previous years, so that providers with extensive systemic issues will be audited more frequently than those with good to excellent compliance ratings.

DMA conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

Service Quality

LMEs are responsible for monitoring providers of residential, day and periodic services licensed under GS 122C and community-based providers not requiring licensure that operate in their catchment areas. Frequency and intensity of local monitoring is determined by a confidence rating for each provider based on the LME's analysis of the provider's past performance history and status with other oversight agencies.

LMEs coordinate monitoring activities with state licensing and oversight agencies to avoid duplication of efforts. LMEs can refer problems identified in the monitoring process to the state for suspension or revocation of license and/or authorization to receive public funding.

LMEs report the results of their monitoring activities to the Division on a monthly basis. Penalties against specific providers are published on a web-searchable Departmental database to facilitate consumers' decisions about choosing appropriate service providers.

Information Systems

In addition to information collected through on-site reviews and investigations conducted by DMA and DMHDDSAS, providers and LMEs submit data on persons served and services received that allow for evaluation of system performance and consumer outcomes. The Division's decisions about data to collect are driven by the reporting requirements of state and federal funding sources and the goals of system reform. The Division manages the major systems described below. DMHDDSAS also has access to department-wide information on providers and consumers, including sanctions against licensed providers, substantiated abuse charges against health care personnel, and vital records.

Service Utilization and Costs

The Division and DMA collect data on consumer services and costs through the Integrated Payment and Reporting System (IPRS), the Medicaid Management Information System (MMIS), and the Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS). While these data systems are designed primarily for oversight of fiscal operations, they provide information that is also useful for determining service accessibility, intensity, and effectiveness.

Consumer Information

Consumer Data Warehouse (CDW): The CDW is the Division's system for collecting descriptive information on all persons served by the state and reporting summaries of that information to state and federal funding agencies.

NC Treatment Outcomes and Program Performance System (NC TOPPS): NC TOPPS is the Division's web-accessed system for collecting information on consumers' service needs and life outcomes. It has been used to collect information on persons receiving certain substance abuse services for several years. In state fiscal year 2005-2006 it will be used to collect outcomes information on all persons ages six and over who are receiving mental health and substance abuse services as part of a target population. In state fiscal year 2006-2007 the system will be expanded to collect information on persons receiving early intervention, prevention, and developmental disability services and supports. Until this expansion is complete, outcomes for a sample of persons with developmental disabilities and persons younger than six are collected

using the paper-based Consumer Outcomes Inventory. These data are used to report NC performance to federal funding sources.

Consumer Perceptions and Experiences

National Core Indicators: The Division currently administers three of the National Core Indicators surveys to collect information from a sample of consumers with developmental disabilities and their family members on their perceptions of and satisfaction with services. Because surveys are conducted in person, the sample has not been large enough to allow for extensive community-level comparisons. However, data are used to compare NC progress with other states who participate in the National Core Indicators project.

MHSIP Consumer Satisfaction Survey: The Division currently coordinates local administration of the satisfaction survey developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to collect information from consumers with mental health or substance abuse disorders on their perceptions of and satisfaction with services. The data are used to report NC progress to federal funding sources and to make comparisons with other states.

Mystery Shopper Programs: The Division is currently working with the CFACs to develop a program to evaluate the performance of the local system in responding to individuals' requests for services. Through this program, individuals call the LMEs' Access Lines with typical scenarios to determine the timeliness and respectfulness of responses. Some LMEs are implementing similar programs to evaluate provider responses and the Department has periodically conducted similar programs to evaluate the Division's responses.

Consumer Services Data Warehouse (CSDW)

The CSDW is a web-accessed system for linking the above databases for state and local analysis of system performance and consumer outcomes. This system currently includes data on service utilization, costs, and consumer characteristics. In state fiscal year 2005-2006 information on consumer outcomes and perceptions will be added to the system. CSDW is continually expanding its easily-accessible summary reports for local, state, and public use in evaluating system performance, while protecting the confidentiality of consumer information.

System Performance Data

The CMS Home and Community-Based Services (HCBS) Quality Framework identifies seven domains that define quality. These domains and the related desired outcomes include:

- Participant Access: Individuals have ready access to home and community-based services and supports in their communities.
- Person-centered Planning and Service Delivery: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
- Provider Capacity and Capabilities: There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.
- Participant Safeguards: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

- Participant Rights and Responsibilities: Participants receive support to exercise their rights in accepting personal responsibilities.
- Participant Outcomes: Participants achieve desired outcomes.
- Participant Satisfaction (with system and processes): Participants are satisfied with their services.
- System Performance: The system supports participants efficiently and effectively and constantly strives to improve quality.

The Division is identifying measures within each of the framework's domains that correspond to federal outcome measures and the goals of the State Plan. Some of these measures are currently collected through the above data systems or other means, and then analyzed, reported and reviewed as part of the LME Performance Contract. Mechanisms for regular collection, analysis and review of data on the other measures will be devised as the reform effort progresses.

Remediation

Remediation refers to strategies used to identify and correct problems quickly and effectively. While responsibility for identifying and correcting problems relies primarily on QA activities, finding ways to prevent future problems of a similar nature also involve QI activities.

The North Carolina system is creating comprehensive mechanisms for identifying and addressing problems at the local level. Coordination of those local processes with state-level policies, training, and oversight ensures that remediation processes are standardized, equitable, and effective.

Addressing Individual Issues

Changes in needed services and supports are addressed by service providers through revisions to person-centered plans and accessing crisis services when necessary. LMEs work with providers to address service problems through changes in services, staff, or provider agencies.

Critical incidents and complaints involving consumers trigger provider responses to ensure the protection of health, safety, and rights of consumers and attempts to find resolutions to disputes that satisfy all parties. LMEs, the Division, DSS, and DFS ensure that appropriate actions have been taken to remedy such issues and prevent their reoccurrence.

Correcting Systemic Service Issues

Issues identified during the provision and supervision of services and receipt of complaints are handled internally by the provider through personnel actions, facility improvements and repairs, revisions to policies and procedures, or other actions. Personnel infractions of a serious nature are reported and published on the Healthcare Personnel Registry maintained by DFS.

When problems within a provider agency are not resolved internally, the LME with oversight responsibilities can provide technical assistance and require and oversee implementation of plans of correction. LMEs refer licensure infractions, abuse allegations, and fiscal improprieties to the appropriate state agency or agencies for investigation, as required by statute, rule or

policy. When an LME is unable to resolve other problems with a provider through technical assistance or corrective actions, the LME can choose to withdraw endorsement of the provider's services and refer monitoring of that provider to the Department (DFS, DMA, and the Division). These agencies can deny, suspend, amend or revoke a provider's license and/or authorization to receive state and Medicaid funding. Such actions are published electronically in the Department's Provider Penalty Database.

Providers are subject to payback for events found not in compliance during fiscal audits. Where instances of fraud or abuse are suspected, the Division and DMA works with the Attorney General and county DSS agencies to investigate and refer criminal actions to the Dept. of Justice.

Correcting System Management Issues

The Division analyzes reports of LME monitoring activities, incident trends, and consumer complaints for timely identification and correction of service problems and health and safety issues. If an LME shows inadequate oversight of providers or an inability to ensure provider improvement, the Division provides technical assistance to the LME as needed.

The Division also analyzes general LME performance, as indicated in the LME Performance Contract reports and annual on-site reviews, and then works with LMEs around specific issues. Statewide issues that emerge are addressed through statewide education and/or changes in Division policies.

The Division undergoes regular fiscal audits by the Department and federal government. In addition the Department monitors the Division's management of contracts with LMEs and other recipient of state funds. Identified problems are addressed through payback of funds, corrective action requirements, and changes in Departmental policies.

Improvement

The improvement function of quality management refers to the use of strategies to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and increasing progress toward goals is an ongoing, creative process that has to involve all participants in the system. Improvement requires structures, processes, and a culture that encourage input from participants at all levels of organizations within the system, sophisticated, thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning.

While the state has long had quality assurance activities and submission of local data in place, regular mechanisms for translating information into actions that improve the quality of the service system are currently in development. DHHS is using a Real Choice Systems Change Grant from CMS to support development of statewide QI processes to facilitate improvement and progress toward the goals of reform.

The requirement for national accreditation of LMEs' service provision, which was instituted prior to system reform, encouraged the development of local improvement structures and processes among LMEs and their contracted providers. LMEs will provide technical assistance and

oversight to ensure development of similar structures and processes among non-contractual service providers.

State-operated facilities, long accredited by national agencies as healthcare organizations, also have long-standing improvement structures and processes in place. Corresponding structures and processes within the Division's Central Office are only now being developed. The Division is creating internal committees with responsibilities for regular review of information on system performance and coordination of improvement projects based on that information.

While coordinated inter-agency improvement activities are still to come, there is increased awareness and discussion among state and local agencies of ways to coordinate data systems and quality management activities. The Quality Improvement Forum and other forums, sponsored by the NC Council of Community Programs and described earlier, are emerging as structures to facilitate discussions of local issues and strategies for improvements across geographic areas. Departmental efforts to integrate service provider and service utilization information across divisions and increased collaboration among oversight agencies in quality assurance activities are laying the groundwork for future cross-agency improvement efforts.

Chapter 6. An Action Plan for Cultural Competence

On March 31, 2004 under the leadership of Secretary Carmen Hooker Odom, the Division and the Office of Minority Health and Health Disparities sponsored a one-day cultural competency workshop. A professional and ethnic cross section of citizen experts representing four racial/ethnic groups (African-American, American Indian, Hispanic/Latino and Asian Islander) from across the state led by Dr. Forrest Toms, a nationally known consultant who specializes in cultural diversity issues, met to develop practical guidance for the Division, LMEs and providers. The citizen experts joined forces in workgroups (in individual breakout sessions by racial/ethnic group) to address a series of brainstorming questions developed to solicit discussion and ideas from the groups. This group of experts set the initial stage for the identification of stigmas to accessing and utilizing services as well as the cultural and linguistic barriers that prevent individuals from seeking services.

Upon the completion of this workshop, the Division recognized the importance and made a commitment to ensure that all components of the publicly funded system of mental health, developmental disabilities and substance abuse services are culturally and linguistically competent. To meet this goal Secretary Carmen Hooker Odom and Division Director Michael Moseley initiated a 15 member Cultural Competence Advisory Group. This advisory group consists of a lead staff person from the Division, two representatives from the racial/ethnic groups identified and invited to the March 2004 workshop. Representatives from a local management entity, provider, state operated facilities and the office of Minority Health and Health Disparities. Technical assistance and resources are provided by Division staff and a consultant that has been working with the Division on its children's System of Care initiatives. Following the initial meeting, a 15 member Cultural Competency Advisory Group (CCAG) was formed to guide the Division's cultural competency development.

This chapter represents the cultural and linguistic competency action plan developed by the Cultural Competency Advisory Group. It continues where the one-day workshop left off. The Cultural Competency Advisory Group identified that the need for the delivery of services that are culturally and linguistically competent is paramount to the transformation of the public system. This transformation and the delivery of culturally competent services are driven by federal legislation and policy, changing demographics within the state and a moral consciousness that this is the right thing to do.

The goal of this action plan is to provide a framework for the future recommendations of the CCAG to the Division, local management entities, providers of services and other stakeholders on the delivery of culturally and linguistically competent services to the people of North Carolina who use the publicly funded system of mental health, developmental disabilities and substance abuse services. The Advisory Group is aware that major changes cannot occur overnight, this is a transformation process, like reform itself, but this transformation process must be woven into the fabric of all reform efforts. Cultural and linguistic competency and the delivery of such services should not be seen as an "add on" to service delivery, but should be integrated in the overall fabric of service delivery, linked to quality of care and legitimized by the leaders of the system in policy, practice, procedures and resources.

The Cultural Competency Advisory Group in developing the contents of this action plan took into consideration reports from many of the nationally recognized experts and organizations on cultural and linguistic competence. The group also reviewed numerous plans from other states to obtain an understanding of the issues that other jurisdictions considered. The Advisory Group used as a foundation recommendations from the final report, *Achieving the Promise: Transforming Mental Health Care in America of the President's New Freedom Commission on Mental Health*. This report specifies that states should improve access to quality care that is culturally competent by responding to the needs of ethnic and racial minority populations by implementing standards, thus building trust, increasing awareness and responding to cultural and linguistic differences.

The recommendations and content of this action plan are congruent with the Surgeon General's Report on Mental Health and its supplement, "Mental Health: Culture, Race, and Ethnicity and federal law, such as Title VI of the Civil Rights Act of 1964. The Surgeon General's Report issued in 1999 emphasized the importance of culture for both patients and providers. The report stated "The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services." This report further documents pervasive disparities in mental health care and those racially and ethnically diverse groups:

- Are less likely to receive needed mental health services and more likely to receive poorer quality of care.
- Are over represented among the vulnerable populations who have higher rates of mental disorder and more barriers to care.
- Face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

Moreover, there is a clear correlation between chronic physical illness and mental illness. According to the supplement to the Surgeon General's Report (2001), chronic physical illness is recognized as a risk factor for mental illness and must be considered within the presence of protective factors such as spirituality, supportive family relationships and availability of health and social services in the community.

Title VI of the Civil Rights Act of 1964 mandates that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." In 2000, the federal Office of Civil Rights issued policy guidance for Title VI and the United States Department of Health and Human Services' Office of Minority Health published final standards on culturally and linguistically appropriate services (CLAS) in health care.

This action plan is meant to be dynamic and is written to provide flexibility to the Division, LMEs, providers and other public partners as they develop and implement a service system that is culturally and linguistically competent.

Why is Cultural Competence Important to North Carolinians?

North Carolina extends east to west for more that 500 miles from the mountainous border of Tennessee to the shores of the Outer Banks. The State comprises a total area of 52, 669 square miles including 3,826 square miles of inland water; 20,043,300 acres of forest land; and 3,375 miles of shoreline on the Atlantic Ocean.

According to the state demographer North Carolina ranks sixth in the rate of state population growth and is the eleventh largest state with a population of 8,049,313. This includes 6,085,266 people who are 18 years of age or older and 1,964,047 who are younger than 18 years of age. The office of State Demographer within the Office of State Management and Budget estimates the population, as of July 1, 2004 to be 8,541,263. This is an increase of 491,950 or 6.1% since the 2000 census.

Nationally and in North Carolina, cultural and linguistic diversity is a growing challenge for health care delivery systems. During the last decade the number of people in need of health care services who have limited English proficiency has risen dramatically. For example, between 1990 and 2000, the Spanish speaking Latino population in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. According to the 2000 United States census, approximately half of North Carolina Latinos have limited English proficiency or are unable to speak English well. Such language barriers can impair a Latino's ability to access needed programs and services, and many are not knowledgeable about how the US health care system works.

Minority and ethnic groups are disproportionately represented within the present mh/dd/sa system. For example, according to the Client Statistical Profile for 2001-2002, African-Americans, who comprise 21.6 percent of North Carolina's population, made up 34 percent of persons served. The Hispanic/Latino population represents approximately five percent of our state's population, yet is less than two percent of active service recipients. There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities.

Adults who are 65 or older have been shown to be at greater risk, are under identified and under served by the MH/DD/SA service delivery system, and they are an increasing component of North Carolina's population. The number of seniors in North Carolina has continued to grow rapidly in the last decade reflecting an increase in the general population and greater longevity. In North Carolina in 2000 there were 969,048 adults age 65 or older. This is 12 percent of the state's residents. These numbers are expected to rise rapidly as "baby boomers" approach retirement. By 2020, the population 65 and older will have grown 71 percent from the 2002 baseline compared to 36% for the general population. North Carolina's population over age 65 has a lower life expectancy, higher rates of poverty and lower average education and income than their national counterparts.

While many seniors are healthy, engaged and living in comfortable circumstances, others face declining health, poverty and social isolation. In 2000, 30.8 percent of people age 65 or older in the community reported some level of physical disability and 12.6 percent reported a mental disability. Forty seven percent of people age 85 or older have Alzheimer's disease. The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S.

Department of Health and Human Services, has noted that older adults often do not recognize the need for or availability of treatment. This results in a gross under utilization of mental health services.

Prevalence of mental health problems among adults 65 or older is as follows: 11.4 percent suffer with anxiety; 6.4 percent have cognitive impairments and 4.4 percent with depression and other mood disorders (SAMHSA 2002). Estimated prevalence for heavy alcohol use varies between 3 and 25 percent (SAMHSA 1998). Alcohol use can be a special problem for those over 65 who are often heavy users of prescription medicines and over-the-counter drugs. This use of prescription medications and over-the-counter drugs places these individuals at increased risk for misuse and adverse drug reactions. Older white men have a six times greater risk for suicide than the general population. It is also estimated that only half of older adults who acknowledge mental health problems receive treatment from any health care provider. The growth of the older population with developmental disabilities is also of major concern. These adults are increasingly outliving their parents and are at risk for losing their primary support. In North Carolina estimates for adults age 60 and over with developmental disabilities range from 5,400 to 13,000. Special attention will need to be given to securing the services and supports necessary to help these older adults remain in the community.

North Carolina's senior population is not a homogenous group but differs in race, ethnicity, gender, marital status and rurality, all of which are factors that affect their risk for mental health, developmental disabilities and substance abuse problems.

The prevalence rates for persons who are culturally deaf, that is, users of American Sign Language (ASL), are estimated at 0.49% of the general population (National Center for Health Statistics). Based on the 2000 Census, sign language users in North Carolina total approximately 37,500.

Culturally competent and language accessible systems demonstrate the capacity to communicate effectively with persons who are deaf or hard-of-hearing and persons with limited English ability and/or low literacy skills. Such organizations have policies, structures, practices, procedures and dedicated resources to support this capacity.

Significant barriers exist to the delivery of linguistically competent health care services. These include but are not limited to the following:

- Health care providers are not typically trained in cross-cultural approaches, which include working with interpreters as necessary to provide language accessible services.
- There are shortages in resources and qualified personnel to provide medical translation and interpretation services especially in rural areas.
- Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

Accurate and honest communication between health care providers and consumers is essential to the effective delivery of quality health care services. Culturally competent and language accessible systems attempt to utilize bilingual professionals and paraprofessionals where

available. Providing interpretation and translation services is another key strategy given the current population profiles and projected trends.

Developing cultural competence within the public mental health, developmental disabilities and substance abuse system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health, developmental disabilities and substance abuse services, including assessment, treatment, habilitation and evaluation (Miller, Peck, Shuman, & Yrn-Calenti, 1995).

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness of one's self; of unstated institutional cultural norms; and of the history, culture, and needs of diverse consumers. To increase cultural competence, service providers must develop an awareness of their own racial and cultural heritage; to understand how that heritage influences their understanding and biases about normality/abnormality and the process of service delivery; and to understand the significant impact of differences both in language and in verbal and nonverbal styles on the process of communication (Atkinson et al., 1998). Mental health, developmental disabilities and substance abuse systems typically operate on unstated Western principles-for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body, and devaluing of altered states of consciousness-which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, providers may impose this Western framework on minority consumers.

The populations that are the subjects of this action plan have all probably experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health, developmental disabilities and substance abuse needs, and their willingness to seek services. Similarly, cultural assumptions affect the system, its practitioners, and its ability to engage minorities.

Some systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and should ask consumers how they understand their problems and what they need.

Values and Principles

Cultural competency is a process based on a set of guiding values and principles. These guiding values and principles must be developed and implemented throughout multiple levels of the organization. The following provides definitions of these guiding values and principles.[17]

Organizational

- Systems and organizations must sanction, and in some cases mandate the incorporation of cultural knowledge into policy making, infrastructure and practice.*
- Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery.*

Practice & Service Design

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.*
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.*
- Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions.*
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

Community Engagement

- Cultural competence extends the concept of self-determination to the community.*
- Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).*
- Communities determine their own needs.**
- Community members are full partners in decision-making.**
- Communities should economically benefit from collaboration.**
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.**

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[17] * Adapted from Cross, T. et al, 1989

** "Other Guiding Values and Principles for Community Engagement" and "Family & Consumers" are excerpts from the work of Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program, and

*** "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.

Family & Consumers

Family is defined differently by different cultures.***

Family as defined by each culture is usually the primary system of support and preferred intervention.***

Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.***

Cultural and Linguistic Competence

It is important to note that there is no one definition of cultural competence. Definitions of cultural competence have evolved from diverse perspectives, interests and needs as are incorporated in state legislation, Federal statutes and programs, private sector organizations and organizational and academic settings.

North Carolina has adopted a definition that encompasses a very broad spectrum of constituency groups that could require assistance or other supports from an organization, agency or provider as the seek services.

We believe that when culture is discussed, it is inclusive to all citizens of the state. Culture includes an individual's traits, customs, religion, country of origin, gender, socioeconomic class, sexual orientation, traditions, values, morals, ways and manners of communication. Therefore, we have modified a definition originally outlined by Davis (1997) to conclude that:

> Cultural competence occurs when, knowledge information and data about individuals and groups is integrated and transformed into clinical and best practice standards, skills, service approaches, techniques and marketing programs that match the individual's culture and increase both the quality and appropriateness of services and outcomes.

While this definition is important the journey toward cultural competence requires that a system of care develop a comprehensive strategy addressing service providers, clinical practices, training, policy, quality assurance, and community outreach.

The Advisory Group believes that to accommodate access and assure an individual's full participation and receipt of maximum benefit from the services being offered, the services must be provided in a manner that recognizes and takes into consideration the individual's ethnicity, cultural differences, language proficiency, communication and physical limitations. Recognizing and accommodating these differences is cost-effective for the public mh/dd/sas system, adds customer value to the services being provided and is fundamental to customer satisfaction. Staff at all levels of the organization need to be sensitive to and appreciate how important accommodation is to effective service delivery. Creating an atmosphere of staff sensitivity to diversity and recognition of the need for accommodation requires a physical plant environment that is designed to be accessible, ongoing staff training, and policies, procedures and practices that promote such sensitivity.

One necessary aspect of cultural competence is linguistic competence and access. Persons with limited English proficiency (LEP) (including those who are deaf or hard of hearing and prefer to use sign language) need to have access to bi-lingual staff or qualified interpreters and translators. A qualified interpreter is sufficiently fluent in both target and source languages so that they are able to accurately interpret to and from either language using any specialized vocabulary needed. The language needs and preferences of persons should be monitored and included in data sets.

North Carolina has adopted a definition that encompasses a very broad spectrum of constituency groups that could require language assistance or other supports from an organization, agency or provider.

To communicate effectively, an organization and its personnel must have the capacity to convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of the population served. The organization must have policy, structures, practices, procedures, and dedicated resources to support the capacity. This may include, but is not limited to, the use of:

- Bilingual/bicultural or multicultural staff.
- Cultural brokers.
- Foreign language interpretation services.
- Sign language interpretation services.
- Multilingual telecommunication systems
- Text Telephones (TTY).
- Assistive technology devices.
- Computer assisted real time (CART) or viable real time transcriptions (VRT).
- Print materials in alternative formats (e.g., audiotape, Braille, enlarged print).
- Varied approaches to share information with individuals who experience cognitive disabilities.
- Materials developed and tested for specific cultural, ethnic and linguistic groups.
- Translation services including those of:
    - Legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications).
    - Signage.
    - Health education materials.
    - Public awareness materials and campaigns.
    - Ethnic media in languages other than English (e.g., television, radio, internet, newspapers and periodicals).

The Cultural Competency Advisory Group (CCAG) is in the final stages of preparing recommendations on cultural and linguistic competence for the Division. Through discussions with the Division Director, staff of the Division is planning a cultural and linguistic competence

training session for the leadership of the Division, state operated facilities and LMEs, followed by a community forum to introduce the recommendations of the advisory group to the general public.

Chapter 7. Evidence Based, Emerging and Promising Practices

North Carolina, with support from a federal Substance Abuse and Mental Health Services Administration/National Institute of Mental Health (SAMHSA/NIMH) planning grant, has developed a plan: (1) to increase stakeholder interest and demand for effective evidence-based services; (2) to provide clinicians and clinical supervisors with the knowledge and skills necessary to deliver evidence-based services for adults with serious mental illness; and (3) to establish mechanisms at the state and local levels to support and maintain effective services.

The North Carolina Practice Improvement Project - Implementing Best Practices in North Carolina

People with disabilities have the right to choose services that are most effective in helping them in their personal goals and on their journey to recovery and self determination. Individuals and families often know what they want to achieve when they seek treatment and service. This is especially so when the assessment and treatment planning process actively engages individuals and families in making these decisions.[18]

State Plan 2003: Blueprint for Change identified three primary values:[19]

- Investing for results.
- "No wrong door" to services and supports.
- Commitment to quality.

The current era of systems transformation practice requires a focus on the content and quality of services and support offered. Quality and accountability involve the adherence to evidence based practice (EBP) and fidelity to those specific program models that are shown to produce consistently cost effective results. Without model fidelity, an organization risks not achieving the positive outcomes demonstrated in the research.[20] In fact growing evidence finds that even some of the most popular and well-disseminated programs are not evidence-based and in fact can be counter productive.[21]

North Carolina has adapted several goals identified by the 2003 President's New Freedom Commission on Mental Health to guide practice improvement.

- Accelerate research to promote recovery, resilience and self determination.
- Advance evidence-based practice using dissemination demonstration projects to create a public private partnership to guide their implementation.
- Improve and expand the workforce providing evidence-based services and supports.

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[18] TAC, 2003.

[19] Changing the Conversation, 2000.

[20] Broskowski, Thompson and Barton, 2004.

[21] Goldman, et al., 2001.

Evidence based practices are those clinical, support and administrative practices that have been proven to consistently produce specific, intended results.

Goal: Develop group of advisors to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, appointed by the Division Director, to participate and advise in all aspects of the process, including literature review, decision making, design, implementation and adjustments to the implementation and evaluation of evidence-based practices.

The Advisory Groups will work to improve the integration of existing research into North Carolina's public service delivery system and to identify areas of study through collaborations between clinicians and researchers. Science will inform the provision of services and the experiences of consumers, family members and service providers will guide future research. They will ensure that each time any North Carolinian – whether a child or an adult, a member of a majority or minority, from an urban or rural area – comes into contact with the DMHDDSAS system, he or she will receive excellent care that is consistent with our scientific understanding of what works (New Freedom Commission on Mental Health, 2003).

Best Practice Disabilities Committees

Each disability group will have a sub-committee to review research on new clinical practices, provide implementation advice and identify problems or issues for additional study. In the transformed system research will be used to develop new evidence-based practices. The groups will also review the results of adoption of practices in the state and provide feedback on implementation issues. They will assist the Division with the acquisition of knowledge about evidence-based practices (the range of treatments services and supports) , as well as emerging best practices (treatment services and supports with a promising but less thoroughly documented evidentiary base) which will be widely circulated and used in a variety of settings.

Membership: An individual disability committee will be composed of clinical leaders, researchers, consumer/family members and policymakers. Two members from different representative areas will be appointed as co-chairs.

Staff Support: Each committee will have a single identified individual to serve as staff support. Responsibilities would include management of communications and scheduling as well as keeping records of the meetings. There will also be an individual from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, acting as communications liaison to each committee. Disability-specific Advisory Committee meetings will be open to the public and minutes will be published on the internet. In addition, the committees may invite public testimony from national and state experts on the subjects they are reviewing or in the clinical areas where they are interested in improving practice.

Operations: Each Advisory Committee will meet four times per year and no less than twice within a period of twelve months. A committee will produce an annual report of its activities, including practices reviewed and recommendations for the state services delivery system.

Annual Best Practice Collaborative

Each spring, all the members of each disability advisory committee will come together to present their annual reports and provide testimony on significant findings and/or concerns. The

meeting will be chaired by the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The meeting of the full Best Practice Collaborative will also serve as an educational opportunity for policy makers, clinicians, consumers, family members, LME leaders and educators to learn about the processes at work to improve clinical practice in the state.

Chapter 8. Goals for State Fiscal Year 2005-2006

Thirty-five key developments have been identified for state fiscal year 2005-2006 that will continue the transformation process. These key developments have been categorized into four areas: Management and Leadership, Finance, Programmatic Issues and Administration and Contracts. Descriptions of how these key developments will be accomplished are provided in this chapter.

Management and Leadership
Key developments to be accomplished in state fiscal year 2005-2006: ✓ Continue to implement information sessions with the leadership of key state agencies and associations to discuss issues related to transformation of the MH/DD/SA system. ✓ Develop outline for the local business plan. ✓ Develop succession plan for continued leadership at the state operated facilities. ✓ Develop succession plan for continued leadership at the Division's central office. ✓ Develop and implement Memoranda of Agreement describing relationships between the Division and other state agencies. ✓ Develop a long range plan for addressing the mental health, developmental disabilities, and substance abuse services needs of the State.

✓ **Continue to implement information sessions with the leadership of key state agencies and associations to discuss issues related to transformation of the MH/DD/SA system.**

The Division of MH/DD/SAS has established Mental Health Reform Information Forums for state agencies and associations. These forums, which occur on a quarterly basis, provide an opportunity for state agencies and associations to receive information on current mental health reform activities and to share their reform-related issues and concerns. There are 25 participating state agencies and 8 state associations. These forums will continue to be held on a quarterly basis and the membership will be expanded as necessary.

✓ **Develop outline for the local business plan.**

In late 2004, Division staff updated the local business plan (LBP) template by removing sections that were either redundant or ones that were no longer applicable due to changes in state policy. Further, the LBP template was cross walked with attachments II and III of the Performance Contract. The cross walk allows staff to match polices required in the LBP that are necessary to implement procedures in support of specific performance measures. As more performance measures are added to the contract over time, cross references to the LBP and the strategic plan will continue to guide policy development at the local program.

✓ **Develop succession plan for continued leadership at the state operated facilities.**

Succession planning is a critical component of insuring the long term success of the developmental centers in providing quality services. While local planning by the center director is an important part of this goal by developing employees who could step into leadership roles, those positions that represent a logical progression to the directorship (program director) need to be studied to insure proper pay grades to attract the best candidates for this progression.

✓ **Develop succession plan for continued leadership at the Division's central office.**

The leadership of the Division has identified the importance of and need for succession planning at the Division's central office. In order to continue transformation and to meet the future challenges of the mental health, developmental disabilities and substance abuse system, a strong Division workforce has to be developed and trained. To accomplish this the Division will initiate a succession planning process that will provide a framework for analyzing the current workforce; identifying future workforce and leadership needs; providing an avenue for long term employees to pass on accumulated knowledge, experience and historical perspective; and identifying and implementing training solutions so the Division can accomplish its mission. This planning process will be designed to ensure continued effective performance of the Division by making a provision for the development and replacement of key people over time

✓ **Develop and implement Memoranda of Agreement describing relationships between the Division and other state agencies.**

There are currently ten Memoranda of Agreement that reflect various relationships between the Division of MH/DD/SAS and other state agencies. Of these, nine are targeted for revision and updating during the State Plan year. Additionally, five new Memoranda of Agreement with state agencies will be considered for development during the State Plan year.

✓ **Develop a long range plan for addressing the mental health, developmental disabilities, and substance abuse services needs of the State.**

The Division in consultation with interested advocacy groups and affected State and local agencies will develop a long range plan addressing the mental health, developmental disabilities and substance abuse needs of the State. This long range plan shall be consistent with the State Plan: Blueprint for Change pursuant to G.S. 122C-102, and shall address:

(1) The service needs at the community level within each LME in order to ensure an adequate level of services.

(2) The full continuum of services needed for each disability group within the LME.

(3) Projected growth in services for each disability group within each LME or region that can reasonably be managed over the ensuing five –year period; and

(4) Projected start-up cost and total funding needed in each year from the Mental Health Trust Fund and bridge funding needs to implement the long range plan.

Finance

Key developments to be accomplished in state fiscal year 2005-2006:

- ✓ Develop finance strategy.
- ✓ Develop and re-evaluate rates.
- ✓ Develop strategic plan for resource development.

✓ Develop finance strategy.

The Division will continue efforts to finalize a finance strategy for the public MH/DD/SA system that will be consumer oriented and focus on optimizing all available resources to continue building community capacity, and identifying and removing barriers that inhibit or prevent effective acquisition and use of resources. Development of this strategy will involve staff from throughout DHHS, other state agencies, legislators, consumers and family members and other stakeholders.

✓ Develop and re-evaluate rates.

During state fiscal year 2004-2005 the Division worked jointly with the Division of Medical Assistance (DMA), DHHS Controller's Office and stakeholders to finalize new services and corresponding rates. The DHHS has submitted a State Medicaid Plan amendment that relates to changing the service rate methodology from cost settled rates to prospective rates and implementing the cost allocation for LME systems management payments. The Division anticipates that this amendment will be approved and is committed to developing and evaluating the rates for payment that will be implemented during state fiscal year 2005-2006.

✓ Develop strategic plan for resource development.

The Division recognizes that successful transformation of the public mh/dd/sa services system will require resources obtained from both private and public sources. To accomplish this task the Division has employed a resource development specialist with primary responsibility for identifying federal and non-federal sources for funding in areas prioritized by the Executive Leadership Team of the Division. During state fiscal year 2005-2006, the Division's resource development coordinator with the assistance of the Executive Leadership Team and the Management Leadership Team will develop a strategic plan for resource development that prioritizes funding needs in order to accomplish the vision of reform.

Programmatic Issues

Key developments to be accomplished in state fiscal year 2005-2006:

- ✓ Submit a self-directed services and supports waiver for persons with developmental disabilities to the federal Centers for Medicare and Medicaid Services (CMS).
- ✓ Successfully implement all new services including those in the new CAP-MR/DD Waiver.
- ✓ Utilization review implementation.
- ✓ Develop three region concept.
- ✓ Enhance collection of data on consumer outcomes and experiences.
- ✓ Develop provider reports.
- ✓ Address homelessness.
- ✓ Study and re-evaluate service definitions.
- ✓ Initiate transition to new service expectations.
- ✓ Implement comprehensive prevention plan.
- ✓ Implementation and evolution of Child Mental Health Plan.
- ✓ Continue to offer technical assistance on community capacity functions of LME.
- ✓ Continue initiative pertaining to traumatic brain injury.
- ✓ Evaluate the availability and access to medications for persons served by the MH/DD/SAS system.
- ✓ Develop best practice for self-directed services.

✓ **Submit a self-directed services and supports waiver for persons with developmental disabilities to the federal Centers for Medicare and Medicaid Services (CMS).**

Work continues to occur on the self-direction waiver using the expertise of those on the Waiver Team and the consultant and continued input from the stakeholder group. Service definitions to be included in the waiver have been identified and work has been progressing on establishing an individual budgeting process. In addition, the Division is moving forward to include American Association on Mental Retardation (AAMR) Supports Intensity Scale (SIS) as an added assessment tool for individuals participating in the waiver.

✓ **Successfully implement all services including those in the new CAP-MR/DD Waiver.**

Services in the new waiver will be implemented by qualified providers as outlined in the provider qualifications section of the waiver. Waiver services provided to waiver participants are determined through the person-centered planning process and outlined in the person-centered Plan of Care.

✓ **Utilization review implementation.**

The type, duration, and intensity of services need to be consistent with the consumer's needs and goals. The purpose of utilization review is to assure quality individualized care, to assure that people get enough care, to reduce unnecessary care, and to reduce variability in practice. There are specific requirements in each of the new and modified service definitions regarding

the frequency for reviewing whether the needs of the consumer are being met by the service that he or she is receiving. Based on this review, a specific service may be reauthorized at the same level of intensity, increased, or decreased. If the consumer is not making progress, this may be an indication that changes need to be made in the Person-centered Plan to more closely match the consumer's needs with services that can effectively address those needs.

In the past, the Division of Medical Assistance has contracted with an organization to conduct utilization review for some mental health services such as outpatient treatment, child residential services, and inpatient psychiatric hospitalization. During state fiscal year 2005-2006, when the new and modified service definitions are implemented, utilization review will be applied on a consistent statewide basis to those Medicaid services. As LMEs demonstrate their capacity to carry out this function, the LME will take on this responsibility. This planned phase-in of the LME role in utilization review will be reflected in the contract between DMA and its statewide utilization vendor.

✓ **Develop three region concept.**

A map displaying the proposed redistricting of the regions from four into three (East, Central and West) has been reviewed by Executive Leadership Team (ELT) and the Secretary. The map and accompanying rules language will be submitted to the Commission on MH/DD/SAS in July 2005. Adoption by the Commission will be followed by communications to all stakeholders regarding the changes in rule and operations processes.

✓ **Enhance collection of data on consumer outcomes and experiences.**

NC TOPPS expansion. Beginning in July 2005 the NC TOPPS web-accessed system will be used for collecting information on the service needs and life outcomes of all persons aged six years and older who are receiving mental health and substance abuse services as part of a target population. During state fiscal year 2005-2006 this information will be made available to LMEs through the CSDW to improve management of services. In state fiscal year 2005-2006 efforts will begin to expand the NC TOPPS system to collect information on persons receiving early intervention, prevention, and developmental disability services and supports.

MHSIP Consumer Satisfaction Survey. For state fiscal year 2005-2006 the Division will begin using the new 28-question version of the annual satisfaction survey for consumers with mental health or substance abuse disorders. The expanded version includes questions that the federal Center for Mental Health Services will be using to evaluate national outcomes for persons receiving mental health services. The Division will also revise the methodology for collecting this survey information to reflect LMEs' divestiture of services and to improve the capacity to gather a more representative view of consumer perspectives.

Institution-to-community transitions interviews. The Division is working with CFACs to conduct in-person interviews with individuals transitioning to community settings after long-term stays in state facilities. These interviews take place during the individuals' first year in community to learn about their experiences during the transition process, monitor progress toward personal goals, and determine any need for additional supports.

✓ **Develop provider reports.**

During state fiscal year 2005-2006 the Division, in collaboration with representatives of CFACs, provider agencies and LMEs, will begin developing statewide information on service providers to support consumers' service choices, LMEs' provider oversight activities and providers' improvement efforts. The Division is currently developing a web-searchable database of information on provider service capacities as well as endorsement, enrollment and licensure status. This database is being developed in phases, with the initial information expected to be available midway through state fiscal year 2005-2006.

✓ **Address homelessness.**

The Division has been successful in obtaining grant funding to provide services through community mental health programs to eligible homeless individuals in the larger urban areas of the state. This funding has enabled these community mental health programs to serve 1,600 individuals through assertive outreach activities and 806 individuals through PATH enrolled activities. During state fiscal year 2005-2006, the Division will use this funding to support outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health, alcohol and drug treatment; staff training; case management; supportive and supervisory services in residential settings; referrals for primary health services; job training, educational services and housing; housing services in compliance with Section 522 (h) (1); and other appropriate services.

✓ **Study and re-evaluate service definitions.**

As the Division transforms the system and implements new service definitions, leadership will evaluate all service definitions to ensure they meet the needs of the people of North Carolina.

✓ **Initiate transition to new service expectations.**

The Division believes that it is important to reiterate that a key to the transition of new service expectations is the clear delineation between the service world of the area program and the systems management world of the LME. LMEs have been working to move from being deliverers of services to managers and coordinators of services delivered primarily through contract providers. In the management world, the LME is the designated leader, responsible for managing and implementing public policy within the local public system. The LME will retain the responsibility to ensure service quality and rights protection served its provider community. The transition from current service definitions to the new service definitions will be fundamental in the Division's efforts to support those best practices that are fundamental to systems transformation.

✓ **Implement comprehensive prevention plan.**

One of the guiding principles of reform of the mental health/developmental disabilities and substance abuse system addresses the importance of prevention and early intervention. It states that research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact of stigma; and lead to earlier intervention and improved treatment.

Division staff has outlined a comprehensive prevention plan to guide the Division, LMEs, providers, consumers, advocates and other stakeholders in promoting prevention and early

intervention statewide for the residents of North Carolina. For purposes of the plan, the Division has established the following definitions:

Prevention is a proactive process and activities aimed at educating, supporting and empowering individuals, families, communities and systems to effectively meet life challenges and transitions by creating and sustaining health, safety and well being. The distinctions between the various types of prevention intervention are based on who is addressed and the probability that the population addressed will experience the potential problem. There is no sure way of knowing if the problem will manifest itself or when. Using the above spectrum, types of prevention are:

- Universal prevention is targeted to the general public or a whole population group that has not been identified on the basis of individual risk. The intervention is desirable for everyone in the group. Cost per individual is lower as is the risk from the intervention. Examples of this type of intervention are prenatal care, healthy living skills, awareness campaigns, screenings and parent-skills training.

- Selective prevention is targeted to a subgroup of the population whose risk of developing a mh/dd/sa problem is significantly higher than average. The risk may be imminent or lifetime and may be identified on the basis of psychological, biological, social or environmental risk factors. Examples are addressing high-risk groups such as children of substance abusers, preschool programs for children with mild behavioral problems, groups for parents with identified risks and children at risk of academic failure.

- Indicated prevention is targeted to high-risk individuals who are identified as having detectable signs or symptoms of a problem, but who do not meet diagnostic levels at the current time. An example is a parent-child interaction training program for children who have been identified as having behavioral problems, children who have experimented with drug-use and those identified as having justice system involvement or mental health problems that would warrant prevention intervention.

Early intervention is the provision of supports and resources to individuals, families and systems at early onset of identified risks, trauma, developmental delays, disability or atypical behaviors to promote and sustain healthy functioning.

Used in this context, the overall aim of prevention and early intervention is preventing the occurrence, delaying the onset of illness or associated problems, the reduction of the occurrence of the illness, reducing the duration of the disorder or halting the progression of severity so individuals do not meet diagnostic levels.

The comprehensive prevention plan is based on a five step logic model as the framework of strategic state and community planning and on a coordinated system of principles, policies and practices for implementing prevention and early intervention activities, services and supports at the state, regional and local levels. This framework will enable the state and LMEs to build the infrastructure necessary for effective and sustainable prevention. Each step contains key milestones that are essential to the implementation process.

The outline review and planning process has begun. Consumers and other stakeholders from state and community entities will be involved in drafting this plan to provide best practice recommendations and an implementation steps for LMEs and CFACs. Implementation is expected to occur over a five-year period and to be updated on an ongoing basis. The next steps include:

- Completing and disseminating the plan in state fiscal year 2005-2006.
- Implementing plan components toward establishing effective and sustainable prevention in communities, such as the communication plan, best practice prevention guidance and mechanism to update/disseminate promising practices, and policies and funding that recognize the essential role of the LME and community partners in coordinating effective prevention.

✓ **Implementation and evolution of Child Mental Health Plan.**

The Division will continue the implementation of the plan to provide children and families with a system of quality care that includes accessible, culturally appropriate, individualized treatment, intervention and prevention services, delivered in the home and community in the least restrictive and most consistent manner possible. During state fiscal year 2005-2006, the Division will continue to implement the following components in coordination with reform:

- Continue to monitor and evaluate CTSP funds and services to assure maximum appropriate utilization to promote person-centered, community based system of care for eligible children and their families.
- Implement communication and training plans.
- Publish and disseminate quarterly newsletters.
- Develop and disseminate best practice guidance and establish mechanisms to update/disseminate promising practices.
- Establish policies and funding that recognize the essential role of the LME and community partners in coordinating effective prevention, early intervention and treatment in the following:
  - School mental health
  - Youth suicide prevention
  - Eliminating Barriers (anti-stigma pubic awareness)
  - Connecting clinical and medical homes for children.
- Provide training and technical assistance to CFACs and community collaboratives.
- Person-centered planning and child and family team facilitation.
- Service definitions.
- Specialized treatment needs.
- Evidenced based and promising practices.
- Monitor LME performance measures.
- Engage in quality improvement strategies.

✓ **Continue technical assistance community capacity functions of LME.**

Division staff will continue to collaborate on the development of community capacity to support consumers moving out of institutional placements. Staff will continue to provide training and

technical assistance to LMEs and indirectly to providers of the new services which are designed to build local capacity.

- ✓ **Continue initiative pertaining to traumatic brain injury (TBI).**

Division staff will produce a systems infrastructure paper to communicate what is needed to improve access to service for individuals with TBI. The TBI Advisory Council will work with the Division on updating a TBI state action plan with an implementation plan attached. If approved, the contract with the Brain Injury Association of NC will work towards increasing public awareness about TBI related issues and work towards improving the local support networks and regional support centers. The Division will strive for relationships that will increase programs to include residential supports, pre-vocational, cognitive and long term support therapies for this population. Our focus will encompass both a statewide and regional information base and resource facilitation model.

- ✓ **Evaluate the availability and access to medications for persons served by the mh/dd/sas system.**

The availability and access to medications for persons in the mh/dd/sas system will continue to be developed as system transformation evolves. While there has been a change in service delivery model, the Division identifies that it is critical to develop an ongoing mechanism for dispersal of medications to the populations served. The availability and access to medications will continue to be an area of focus.

- ✓ **Develop best practice for self-directed services.**

The Division will develop structures that make it possible for individuals with disabilities to choose self-directed options for the delivery of services. Self-directed services are those in which the consumer has maximum choice and control over services and supports; decides which services to use within a budget; and chooses to select, supervise and dismiss staff.

Administration and Contracts

Key developments to be accomplished in state fiscal year 2005-2006:

- ✓ Implement the recommendations of the Cultural Competence Advisory Group.
- ✓ Oversee key components in the development of the new hospital at Butner.
- ✓ Continue quality improvement initiatives for the MH/DD/SA services system.
- ✓ Continue to develop policies of state operated facilities wherever possible to consolidate for uniformity the operations of the state service delivery system.
- ✓ Implement the strengthening and enhancement of the Division's accountability efforts.
- ✓ Develop performance measures around the functional efforts of CFACs.
- ✓ Develop and implement strategies for training and workforce development.
- ✓ Continue housing initiatives for persons served by the MH/DD/SAS system.
- ✓ Advance the opportunities for people with disabilities and their families to influence the full range of the system.
- ✓ Publish State Plan 2006.
- ✓ Develop new or modify existing rules and statutes that reflect MH/DD/SAS reform.

✓ **Implement the recommendations of the Cultural Competence Advisory Group.**

The Division recognizes the importance of and has made a commitment to ensure that all components of the publicly funded system of mental health, developmental disabilities and substance abuse services are culturally and linguistically competent. The recommendations of the Cultural Competency Advisory Group will be delivered to the leadership and the Division and the public during a Cultural Competence Workshop sponsored by the Division during the first quarter of state fiscal year 2005-2006.

✓ **Oversee key components in the development of the new hospital at Butner.**

The steering committee will continue to oversee the construction and occupancy planning efforts for the new hospital.

✓ **Continue to develop policies of state operated facilities wherever possible to consolidate for uniformity the operations of the state service delivery system.**

The current initiative with the greatest impact on systems uniformity is the development of information technology and systems infrastructure for the new central region hospital. The clinical automation vision for a "state-of-the-art" facility will provide insight into improvements for all other state operated facilities. To that end, representatives from all facilities and from across all professional disciplines within the facilities participated in the collection of requirements for the new system. While the first implementation will be at the new hospital, the plan includes subsequent implementation across all of the psychiatric hospitals, developmental centers, alcohol and drug addiction treatment centers and skilled nursing facilities. Two Requests for Proposal (RFP) will be let during the summer of 2005. The Clinical Transformation RFP will aid

in selecting a group to evaluate the current clinical and business practices of the hospitals in order to streamline the process in preparation for automation. The New Hospital IT/IS RFP will target IT/IS vendors that can support the systems required for the new hospital and, subsequently, other state operated facilities.

State Operated Services will continue efforts to accomplish this goal while recognizing the uniqueness of each facility. A recent example of this in the DD Centers has been the review of admissions policies related to guardianship so that the policies are uniform. Another example is the establishment of Transition Coordinators at each facility to ensure that downsizing efforts are managed similarly.

✓ **Implement the strengthening and enhancement of the Division's accountability efforts.**

During state fiscal year 2005-2006 Division staff strengthened and enhanced accountability efforts by supporting the local and state partnership for monitoring the quality and appropriateness of mh/dd/sa services to help LMEs perform regular monitoring visits. Division staff will continue to participate in independent complaint investigations. Further, staff will perform Medicaid Audits for existing mh/dd/sa Medicaid services and CAP-MR/DD services and will perform monitoring reviews for the DHHS-LME Performance Contract items that require onsite review. Division staff also works with DMA by receiving, aggregating, and submitting to DMA provider endorsement reviews completed by LMEs for enrollment in Medicaid. Finally, Division staff oversees sub-recipient monitoring requirements of the Division for assurance of compliance with federal grants and funding which support system reform and serves as planning and information focus for national accreditation of service providers and LMEs per DHHS-LME Performance contract and Medicaid service definitions.

✓ **Develop performance measures around the functional involvement of CFACs.**

During state fiscal year 2005-2006, the Consumer Empowerment and LME Systems Performance Teams of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) will develop a monitoring tool in an effort to provide meaningful and useful insight into consumer and family participation in the planning of the local service system. This document will be designed with the intent of supporting the LME, CFAC and DMH/DD/SAS staff in considering for themselves consumer/family participation, developing outcomes and strategies for increasing meaningful participation of consumers/families and moving forward as partners.

✓ **Develop and implement strategies for training and workforce development.**

Long-term initiatives:

Statewide Network –

- To continue to gather data through research and by bringing in national experts to describe and explain similar national efforts. Preliminary set of recommendations expected by June 30, 2006.
- To add representation from direct support workers.

Local Networks – To develop and disseminate an inventory of required training, to begin a process for sharing resources and to communicate with education and training providers in their areas.

Annual initiatives:

- Expand the NC Learning Community by developing further partnerships with Area Health Education Centers, universities, the LME Academy and other training providers.
- Reform Issues – Work collaboratively through the NC Learning Community to develop training in related issues such as medical necessity, completing person-centered plans, utilization review, provider communities and others.
- Service Definitions and Person-Centered Planning

  -Increase training capacity for providers by training trainers, sponsoring training and endorsing training/trainers.

  -Increase training depth for providers by setting up requirements for competency-based training, minimum training time, targeting audiences and trainer support and management.

  -Continue to work with the NC Council of Community Programs to participate in development of relevant training events through the LME Academy.

✓ **Continue housing initiatives for persons served by the MH/DD/SAS system.**

The Division intends to provide leadership on housing resource development within its new structure. In addition to promoting linkages and the exchange of information between LMEs, the Division will provide technical assistance and training on ways to maximize existing housing resources and best practice in developing residential and supportive housing services. Local LME and Division initiatives will coordinate across agency lines, at the state and local level and support DHHS efforts to speak and act collectively in our approach to the affordable housing system for the benefit of extremely low income persons with disabilities.

✓ **Advance the opportunities for people with disabilities and their families to influence the full range of the system.**

The State Consumer and Family Advisory Committee (SCFAC) in conjunction with the Division's Executive Leadership Team (ELT) will continue input and conduct oversight of the Division's operations and efforts to accomplish the strategic outcomes of the State Plan. Participation at the state level ensures direct access to the ELT to provide input into the Division's policies and planning and to bring forward the concerns and input of the local CFACs in their communities. The SCFAC reports directly to and will meet with the Secretary of DHHS at least annually to provide a summary of the SCFAC's perspective regarding Division efforts. The Division will provide the SCFAC with technical assistance and training to ensure its successful performance. In addition, SCFAC members have been encouraged by both the Secretary and the Division Director to communicate with them at any time about any concerns.

✓ **Publish State Plan 2006.**

The State Plan is a living document that is modified and updated annually as the Division implements strategies, analyzes data and receives feedback from various stakeholders, CFAC members and citizens of the state. The Plan will be published and presented to the public on July 1, 2006. It is the Division's intention that State Plan 2006 will be a comprehensive document that will provide the foundation for the next phase of the system's transformation efforts.

- ✓ **Develop new or modify existing rules and statutes that reflect MH/DD/SAS reform.**

The Division of MH/DD/SAS has established a timeline through May 2006 for developing and amending Administrative Procedure Act rules which will reflect mental health reform.

- ✓ **Implement academic oversight process to continue to evaluate evidence based and emerging best practices.**

The Division will work to build partnerships with academic institutions that can assist the Division in evaluating evidence based and best practice models of service delivery.

Acronyms

AAMR	American Association on Mental Retardation
ADA	American Disabilities Act
ADATC	Alcohol and Drug Abuse Treatment Center
ADETS	Alcohol and Drug Education Traffic School
AHEC	Area Health Education Center
AOC	Administrative Office of the Courts
AP	Area Program
ASAM	American Society of Addictive Medicine
CAP	Community Alternatives Program
CAP–MR/DD	Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities
CARF	Commission on Accreditation of Rehabilitation Facilities
CCAG	Cultural Competency Advisory Group
CCSW	Certified Clinical Social Worker
CDSA	Children's Developmental Services Agency
CFAC	Consumer and Family Advisory Committee
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CJO	Criminal Justice Offender – Child or Adult Population
CMS	Centers for Medicare/Medicaid Services
CO	Controller's Office
CSAT	Center for Substance Abuse Treatment
CSDW	Client Services Data Warehouse
DCD	Division of Child Development
DD	Developmental Disability
DHHS	Department of Health and Human Services
DIRM	Division of Information Resource Management
DJJDP	Department of Juvenile Justice and Delinquency Prevention
DMA	Division of Medical Assistance
DMH/DD/SA	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DPH	Division of Public Health
DPI	Department of Public Instruction
DSDHH	Division of Services for the Deaf and Hard of Hearing
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
DSS	Division of Social Services

DWI	Driving While Impaired Treatment
EAP	Employee Assistance Program
ECAC	Exceptional Children's Assistance Center
ELT	Executive Leadership Team
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FFK	Families for Kids
FISH	Fresh Ideas Start Here
G.S.	General Statute
GAF	Global Assessment of Functioning
HC	Health Check
HC	Health Choice
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIS	Health Information System
HMT	High Management Substance Abuser - Adult Population
HOM	Homeless Child or Adult Substance Abuse Population
HOME	Home Investment Partnership
HUD	Housing and Urban Development
ICC	Interagency Coordinating Council
ICD	International Classification of Diseases codes
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility – Mentally Retarded
IDEA	Individuals with Disabilities Education Act
IPRS	Integrated Payment and Reporting System
IT	Information Technology
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
LEA	Local Education Agency (Local Public School System)
LME	Local Managing Entities
LOC	Legislative Oversight Committee
LOC	Level of Care
LTC	Long Term Care
MAJORS	Managing Access for Juvenile Offender Resources and Services
MCH	Maternal and Child Health
MED	Seriously Emotionally Disturbed - Child Population
MHTF	Mental Health Trust Fund
MLT	Management Leadership Team
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

MR	Mentally Retarded
NAMI	National Alliance for the Mentally Ill
N.C.	North Carolina
NCAC	North Carolina Administrative Code
NCHC	North Carolina Health Choice
NC LEADS	North Carolina's Medicaid Management Information System
NCSCC	North Carolina Special Care Center
NC TOPPS	North Carolina Treatment Outcomes and Program Performance System
ORDRHD	Office of Research, Demonstrations and Rural Health Development
PASARR	Preadmission Screening and Annual Resident Review
PATH	Homeless (PATH) - Child or Adult Mental Health Population
PL	Public Law
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
REOMB	Recipient Explanation of Medicaid Benefits
RFA	Request for application
RFI	Request for information
RFP	A Request for Proposal
SAD	Substance Abuse Disorder - Child
SAMHSA	Substance Abuse and Mental Health Services Administration
SBI	State Bureau of Investigation
SCFAC	State Consumer and Family Advisory Committee
SED	Seriously Emotionally Disturbed
SNAP	Support Needs Assessment Profile
SIS	Supports Intensity Scale
SOC	System of Care
SOS	State Operated Services
SP	Selective Prevention - Child Population
SPM	Severe and Persistent Mental Illness
TASC	Treatment Accountability for Safer Communities.
TEACCH	Treatment & Education of Autistic and Related Communication Handicapped Children
TTY	Text Telephone
WOM	Women with Substance Abuse Disorders - Child or Adult Population

Glossary

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACUITY – (or acuity level) Used, most often in hospital settings, to describe the intensity of a person's needs for care.

ACUTE ABSTINENCE SYNDROME - A group of withdrawal signs and symptoms that occur shortly after a person who is physically dependent on a drug stops taking it.

AVERAGE DAILY CENSUS (ADC) – Measurement of the number of people residing in a residential program, usually hospitals.

ADULT CARE HOME – An assisted living residence in which 24-hour scheduled and unscheduled personal care services are provided to two or more residents. Some licensed adult care homes provide supervision to people with cognitive impairments who need supervision because their decisions, if made independently, may jeopardize their own or others' safety or well being. Designated, trained staff home may administer medications. Adult care homes that provide care for two to six unrelated residents are commonly called family care homes.

ADVANCE DIRECTIVE - A legal document that allows consumers to plan their own mental health care in the event the individual loses the capacity to effectively make decisions. The individual can name a friend and/or an agent (friend or family) to act on his/her behalf to give guidance to the professionals involved in care, treatment according to his/her preferences. Completing an advance directive is an opportunity for the person with disabilities to learn more about the illness and have more control what happens.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes. On example of advocacy and consumer empowerment is participation in state or local CFACs.

AFTERCARE- Supervision or treatment given individuals for a limited time after they are released from a treatment program.

ALCOHOL, TOBACCO, AND OTHER DRUGS (AOD) – Substance abuse treatment.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of **patient placement criteria** that have been widely used and analyzed in the alcohol, tobacco and other drug (ATOD) field.

APPEALS PANEL - The state mh/dd/sa appeals panel established under NC. G.S. 371 and G.S. 122C-151.4

AREA DIRECTOR – The executive who is responsible for mental health, developmental disability, and substance abuse services in a county/area program. This person has at least a master's degree in a behavioral health services discipline and is responsible for developing a system of care in his/her **local** area that brings all possible public and private services into a network. The network must meet the needs of service consumers in that region and conform to the requirements of the DMH/DD/SAS.

AREA/COUNTY PROGRAM – A program that is certified by the DHHS Secretary to manage, oversee and sometimes directly provide mental health, developmental disabilities and substance abuse services in a specified geographic area. Most area programs have already changed or will soon be changing to Local Management Entities.

ARRAY OF SERVICES - Group of services available to a consumer.

ASSERTIVE COMMUNITY TREATMENT (ACT) – A research-based, multi-disciplinary team providing community-based treatment, rehabilitation and support services to consumers who are at risk of frequent decompensation and hospitalization, arrest or homelessness. ACT teams maintain primary clinical responsibility and provide services 24 hours a day, seven days a week on a long-term basis. This allows for continuity of caregivers, and thus for increased stability in community living.

ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTONOMY – An ethical principle that requires policy-makers, advocates, planners, administrators, providers and family members of adult service consumers to respect the right of legally competent individuals to make decisions about the course of their lives.

BASIC BENEFITS – Services for people who are not members of a target population but who are Medicaid eligible. Eight units for adults and 26 units for children are pre-authorized.

BED DAY ALLOCATION – A system in which the DMH/DD/SAS sets the number of state psychiatric hospital beds or mental retardation center admissions county/area programs may "buy" in a particular time period. These allocations take into account past usage and private beds available in each geographic area**.**

BENCHMARK - An established standard of achievement used as a point of reference to assess performance.

BEST PRACTICE (S) – Interventions, treatments, services or actions that have been shown to generate the best outcomes or results. The terms, evidence-based, or research-based may also be used.

BIOPSYCHOSOCIAL – Medical (biological), psychological, and social or environmental influences on a person's behavior and/or condition.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. See also, **CATEGORICAL FUNDING.**

CAP/MR-DD WAIVER – A Medicaid community care funding source for persons with MR/DD who require an ICF/MR level of care that offers specific services in the community.

CASE MANAGEMENT –The activities of a professional with a great deal of knowledge of the services and programs supported by the public mh/dd/sa system who advocates for access and links individuals to the services. Case managers may be publicly or privately provided.

CATCHMENT AREA- The geographic part of the state served by a specific area or county program.

CATEGORICAL FUNDING – Funds provided for specific purposes or for services to specific people.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - The federal agency responsible for overseeing the Medicare and Medicaid programs.

THE CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) - A federal organization that provides national leadership in development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the

negative consequences of using substances. CSAP is one of three Centers in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS).

THE CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT) - of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.

CERTIFICATION – A statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. CMS is an example of a certifying agency. See also **ACCREDITATION.**

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS) – Measurement system to determine the level of functioning of a child or adolescent.

CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM (CA LOCUS) –System used to determine the appropriate level or intensity of services/supports for children and adolescents.

CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT (CRIPA) - Federal law intended to assure that persons involuntarily detained in state psychiatric hospitals or mental retardation centers are treated safely, humanely and with adequate due process as required under the U.S. Constitution. CRIPA investigations are undertaken and litigated by the Department of Justice, Civil Rights Division.

CLAIM – An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.

CLIENT - An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee. See also **CONSUMER.**

CLINICAL SERVICES - In mh/dd/sa services, this usually means activities of medical and related professionals. These professionals generally include psychiatrists, social workers, psychologists, nurses and counselors.

CLINICAL BEST PRACTICE – Consumer-focused, evidenced-based interventions and/or clinical services that demonstrate the best outcomes for consumers.

CLINICAL SUPERVISION - Intermittent face–to–face contact between a clinical supervisor and treatment staff to ensure that each person being served has an individualized treatment plan and is receiving quality care. It also includes auditing patient files, review and discussion of active cases and direct observation of treatment. In substance abuse treatment, it also means applying supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility, problem identification and resolution, referral for screening, specialized education, alternative activities development, social policy development, environmental change, training and development of risk reduction skills.

COMMUNITY SUPPORT - Refers to three specific service definitions. The definitions include (1) Community Support for Adults with MH or SA and (2) Community Support Teams for Adults with MH or SA provide rehabilitations services and supports to assist the person to achieve and

maintain rehabilitative, sobriety, and recovery goals; (3) Community Support for children with MH or SA provides interventions designed to assist with skills, support ongoing treatment. All of these Community Support services include responsibility for the development of Person Centered Plans, case management functions, and for providing most of the services in the home or other community locations rather than being office based.

COMPETENCE – The capacity to function effectively. Also a legal term (i.e. competency to stand trial or competency to make decisions in one's own best interest). An individual must be judged incompetent in a court of law or found dangerous to self or others before the person's civil rights may be restricted.

COMPLAINT – An expression of concern in writing or orally regarding rights, services or administrative issues that the complainant perceives as a problem.

CONSULTATION – Information shared between or among peers or professionals to increase the ability to manage challenging circumstances. Psychiatric consultation to a cardiologist who is treating a depressed patient is an example. A social worker might consult with another on the best residential placement for an individual with severe and persistent mental illness.

CONSUMER – An individual who has been or is receiving publicly funded mental health, developmental disability or substance abuse services or supports. See also **CLIENT.**

CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC) – A committee of ordinary people who get help from the area program or whose loved ones do. It is their job to advise the area program how to design the reformed system.

CONSUMER OUTCOMES - The extent to which individuals receiving services and supports designed to assist in this process reach their life goals. For example, an adult consumer is competitively employed or a child with severe emotional disturbance who attends school regularly.

CO-OCCURRING DISORDERS – The presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions). See also, **DUAL DIAGNOSIS**.

CORE SERVICES – Services such as screening, assessment, crisis or emergency services available to any person who needs them. Also, universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.

CRISIS – Response to stressful life events that may seriously interfere with a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself.

CRISIS INTERVENTION - Services and supports aimed at helping a person manage a crisis safely and return to his or her regular life.

CRISIS SERVICES – Immediate response to assess for acute mh/dd/sa service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate crisis stabilization services. These services are available 24 hours per day, 365 days per year.

CRISIS STABILIZATION – Services and supports following crisis response that are intended to assist the person in crisis to return to his/her regular life.

CULTURAL – A group of learned behaviors that a certain group of people have in common. They include thoughts, communications, actions, customs, beliefs, values and institutions of different racial, ethnic, religious, age or social groups.

CULTURAL COMPETENCE –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing acceptance and understanding of others.

DE-INSTITUTIONALIZATION – Release of people, especially mental health patients, from institutions to care, treatment and supports in communities. , De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in OLMSTEAD V. LC has given new momentum to development of community based services for individuals who have remained in state hospitals and mental retardation centers because community services were not available.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees state government human services programs and activities.

DETOXIFICATION - A medically supervised treatment program for alcohol or other drug addiction designed to purge the body of intoxicating or addictive substances. It is often used as a first step in overcoming physical or psychological addiction.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:
a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay. GS131D-2

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe mh/dd/sa disorders.

DIAGNOSTIC ASSESSMENT - An intensive clinical and functional face to face evaluation of a recipient's mental health or substance abuse condition that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes an order for enhanced benefit services that provides the basis for the development of an initial person-centered plan.

DIMENSION - A term used in the ASAM (American Society of Addiction Medicine) patient placement criteria referring to one of six patient problem areas that must be assessed when making placement decisions.

DIRECTLY ENROLLED PROVIDER - Provider organizations that provide services and seek reimbursement from Medicaid. Such providers are subject to the LME endorsement process. (See http://www.dhhs.state.nc.us/mhddsas/announce/commbulletins/commbulletin-037provider4-22-05memoall.pdf)

DIVERSION –Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a state hospital. The term is also used when preventing arrest or imprisonment by placing the individual in treatment. See also, **UTILIZATION REVIEW** and **PRE-AUTHORIZATION**.

DIVERSION PROGRAMS - Programs designed to screen people out of the criminal justice system and into appropriate treatment services before they are imprisoned. In North Carolina diversion programs are in place in response to SB859 which prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DOMAINS - major areas of concern to the NC public mh/dd/sa system and its mission, goals, and strategies and for which indicators and measures are developed. Examples include access to services and quality of care. The term may also refer to major areas of functioning in life, such as personal relationships, work, school and living arrangements.

DUAL DIAGNOSIS – Having more than one disorder or condition such as physical illness and mental illness, mental illness or developmental disability and substance abuse. Since the word dual implies two and it is possible for an individual to have many conditions or disorders, CO-OCCURRING DISORDERS is the more accurate term.

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) – Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. See also, **PREVENTION**. Also, activities or programs designed to ensure that service providers are competent to provide services; identified as best practices.

EMERGING PRACTICES - Treatments and services that are promising but less thoroughly documented as defined by the President's New Freedom Commission on Mental Health

ENHANCED BENEFITS – Refers to the enhanced benefit service definition package for persons with complicated service needs. The service philosophy includes expectations of "no wrong door," access to service 24/7/365, and service that begins with the first contact with a provider. For persons receiving enhanced benefits, initial treatment or service occurs at the same time that a Diagnostic Assessment is ordered and person-centered planning begins.

EVIDENCE BASED PRACTICES - as defined by the Institute of Medicine (IOM), is the integration of best research evidence with clinical expertise and patient values.

FAMILY SUPPORT – Persons identified by the consumer as either family members or significant others who provide the necessary support for furthering quality of life, attainment of personal life goals or recovery.

FEDERAL CONFIDENTIALITY LAW GOVERNING ALCOHOL AND DRUG ABUSE PATIENT RECORDS, 42 CFR, part 2 - A federal statute regulating the release of alcohol and drug abuse patient records and patient identifying information.

FIDELITY SCALES - Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Such scales have been developed for each of the six EBPs included in the Implementing EBP Project (assertive community treatment, supported employment, integrated treatment for dual disorders, illness management, family psychoeducation, and medication guidelines).

FOLLOW-UP - Checking on the progress of a person who has completed treatment or other services, has been discharged or has been referred to other services and supports.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area.

HABILITATION – Activities, treatments, services and/or supports that assist the individual to effectively accomplish activities of daily living.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current service consumers are not discriminated against based on health status.

HOME AND COMMUNITY BASED SERVICES (HCBS)- Refers to a federal waiver of Medicaid requirements permitted under the Social Security Act that permits payment for services not ordinarily covered by the Medicaid state plan or to be delivered in a different amount, duration, and scope than services offered by the Medicaid state plan. Federal regulations under the waiver may target specific groups of individuals, such as persons with developmental disabilities, traumatic brain injury, or chronic mental illness, or target specific geographic areas of a state. It also permits the state to set different financial eligibility limits so that additional persons may become eligible for Medicaid through the waiver.

INPATIENT – A person who is hospitalized**.**

INTERMEDIATE CARE FACILITY (ICF) - An institution licensed under state law to provide health related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility (SNF) provides.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES (ICFMR/DD) – A facility that provides ICF level of care to eligible persons who have mental retardation or developmental disabilities.

INDICATORS - Measurable evidence of the results of activities related to a particular area of concern. Examples include the percent of adult consumers employed or the percent of children with serious emotional disturbance attending school regularly.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system used to track, pay and report on all claims submitted by providers for services rendered. Area authorities/County programs will submit a single claim to the state, and the IPRS processes the claim from the appropriate funding source.

INTENSITY OF NEED – A measurement of the amount, duration, scope, frequency and cost of a benefit package for a specific individual.

INTENSITY OF SERVICE - The degree or extent to which a treatment or service is provided, depending on a patient' level of need. Some treatments and services are considered more intensive than others. For example, medically managed inpatient treatment is more intensive than outpatient treatment, or a halfway house. Other services, such as vocational training, can be more or less intense, depending on patient needs.

INTERVENTION - Activities aimed at interrupting an action or a behavior that is harmful to progress and recovery.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) – Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LEVEL OF CARE (LOC) - A structured system of types of care. For substance abuse programs, as used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A state or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LOCAL BUSINESS PLAN – A comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGEMENT ENTITY (LME) - The local agency that plans, develops, implements and monitors services within a specified geographic area according to requirements of the DMH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services and/or supports for both insured and uninsured individuals. See also area/county program.

MEASURES - Methodologies applied to derive and calculate indicators of performance.

MEDICAID – A jointly funded federal and state program that provides hospital and medical expense coverage to low-income individuals and certain elderly people and people with disabilities.

MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided. Review methods include retrospective, concurrent and pre-treatment reviews. See **UTILIZATION REVIEW**.

MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with disabilities.

MEDICARE PART A – The part of Medicare that provides basic hospital coverage automatically for most eligible persons over sixty-five or for people with disabilities.

MEDICARE PART B – A voluntary program that is part of Medicare and provides benefits to cover the costs of physician services.

MEDICARE SUPPLEMENT – A private medical expense insurance that supplements Medicare coverage. Also known as a Medigap policy.

MEMORANDUM OF AGREEMENT (MOA) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MEMORANDUM OF UNDERSTANDING (MOU) – Same as MOA

MENTAL ILLNESS – Collective term for all mental disorders. See also, **MENTAL HEALTH, SERIOUS MENTAL ILLNESS,** and **SERIOUS AND PERSISTENT MENTAL ILLNESS**.

MODEL FIDELITY – Adherence to evidence based practice (EBP) and fidelity to those specific program models that are shown to product consistently effective results.

NATURAL SUPPORTS - Places, things and, particularly, people who are part of our interdependent lives and whose relationships are reciprocal in nature and often vital to consumers' welfare.

NC TOPPS - NC TOPPS is the Division's web-accessed system for collecting information on consumers' service needs and life outcomes to provide a stable, credible, useful, and efficient system for reporting performance and outcomes for North Carolina substance abuse services. The purpose of NC-TOPPS is to integrate performance and outcome monitoring into the ongoing operations of area programs and contract agencies and work toward the establishment of a quality management approach.

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.

NON-TARGET POPULATION – Individuals whose needs are met by community resources.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OLMSTEAD v. LC – A U.S. Supreme Court decision that found that people with disabilities have a right to choose services in the least restrictive environment. North Carolina has an OLMSTEAD Plan in place to develop more community-based services for many people who currently reside in state institutions.

OUTCOMES MEASURES – At the individual level, events used to determine the extent to which service consumers improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, these are events used to determine if the system is functioning properly.

OUTPATIENT SERVICES – A collection of services for persons with mental illness or addiction disorders. They may include any of the following but are not limited to assessment, medication management, psychotherapies, family therapy, care coordination or case management, supportive employment programs, housing assistance, rehabilitation programs and activities, Assertive Community Treatment (ACT), Homeless Outreach, prevention programs, and others. Outpatient services can be provided in a variety of settings, including the person's home, and contain a few or any number of service elements.

PAID SUPPORTS - The people, places and things that are part of our lives because we purchase them in order to achieve specific outcomes.

PEER SUPPORT – Services offered by mental health consumers, persons with addictions or others to provide support to one another. Peer support services can include drop-in centers, bridge programs, warm lines, peer respite care or support groups. Peer support services are often a part of rehabilitation and recovery programs.

PERFORMANCE IMPROVEMENT – A quality improvement process of measuring and improving system performance, especially regarding key domains of interest.

PERFORMANCE MEASURES – Quantitative measures of the quality of care provided by a provider that consumers, payers, regulators and others can use to compare the care or provider to other care or providers.

PERIODIC SERVICES – Short-term re-occurring visits over time.

PERSON-CENTERED PLANNING - A process concerned with learning about the individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. The planning process is interested in learning who the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community mh/dd/sa system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.

PRE-AUTHORIZATION – The process of approving use of certain resources in advance rather than after the service has been provided. Approval for admission to hospitals is one example.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal prevention programs reach the general population; selective prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; indicated prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PRIOR AUTHORIZATION – A managed care process that approves the provision of services before they are delivered.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PROVIDER – A person or an agency that provides mh/dd/sa services, treatment, supports.

PSYCHOSOCIAL REHABILITATION – A variety of social, learning, vocational and community living skill-building programs. Programs that focus on principles of recovery often achieve very successful outcomes.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly funded services to consumers.

QUALIFIED PROVIDER – A provider who meets the provider qualifications as defined by rules adopted by the Secretary of Health and Human Services.

QUALITY ASSURANCE (QA) - process to assure that services are minimally adequate, client rights are protected, and organizations are fiscally sound. QA involves periodic monitoring of compliance with standards. Examples include:

- Establishment of minimum requirements for documentation and service provision.
- Licensure and certification of individuals, facilities, and programs.
- Investigation of allegations of fraud and abuse.

See also, **QUALITY MANAGEMENT**.

QUALITY IMPROVEMENT (QI) – process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. The goals of QI are consistent with the mission and vision of the Division. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI) is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers. QI consists of the regular and systematic assessment of vital indicators of organizational performance (i.e., data), the identification and evaluation of trends, and when problems are identified, systematic problem-solving to develop solutions to the identified problems. Special teams may be developed to further investigate and propose solutions to identified problems. Solutions to organizational problems are implemented by quality improvement teams and are systematically evaluated for effectiveness and on-going problem-solving until a satisfactory resolution is reached. QI is proactive, seeking opportunities to continually improve processes to achieve better outcomes. Examples include:

- Forming teams to identify data to be collected, retrieve the data, analyze it and design improvements in the system.
- Development and implementation of evidence-based practice guidelines.
- Conducting targeted studies to determine how to improve service delivery.

QUALITY MANAGEMENT (QM) - framework for assessing and improving services and supports, operations, and financial performance. Processes include:

- Quality assurance, such as external review of appropriateness of documentation.
- Quality improvement, such as design and implementation of actions to address access problems.
- Utilization review, such as the review of case records to determine appropriateness of services and documentation.
- Utilization management, such as the pre-authorization of inpatient services.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow–up in a timely manner consistent with best practice guidelines.

RESPITE CARE – A service designed to provide temporary care for a person with a disability who ordinarily lives with family or friends, or to assume temporary responsibility for care of the person in his/her own home. This service provides back-up support and in some cases relief to persons responsible for care of ill or people with disabilities who ordinarily live in their household.

SAFETY NET - The responsibility of the public mental health, developmental disability and substance abuse services system to serve, treat and support seriously ill people who, no matter how needy, would not otherwise receive services.

SCREENING – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people under 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services.

SEVERELY MENTALLY ILL (SMI) – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people whose mental disorder is so severe and chronic that it prevents or erodes development of their functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities. Same as **SERIOUS, DISABLING MENTAL ILLNESS AND CHRONIC MENTAL ILLNESS.**

SERVICE – A fixed and defined arrangement, such as social work services or nursing services, which are delivered within a scope of professional practice.

SERVICE MANAGEMENT - At the consumer level, this means a professional, with a great deal of knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of state facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALTY SERVICES - Services provided to people with disabilities that affect relatively few people.

SSA – The Social Security Administration agency designated by the governor and the state government to coordinate state substance abuse services across government lines.

STANDARDS – Activities generally accepted to be the best method of practice. Also, the requirements of licensing, certifying, accrediting, or funding groups.

STANDARD OF CARE – A diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness or clinical circumstance.

STATE MENTAL HEALTH AUTHORITY – The single state agency designated by each state's governor to be responsible for the administration of publicly funded mental health programs in the state. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES PLAN – The annually updated statewide plan that forms the basis and framework for mh/dd/sa services provided across the state.

STATE OR LOCAL CONSUMER ADVOCACY COMMITTEE MEMBER - The individual carrying out the duties of the state Local Consumer Advocacy Program Office

STIGMA – In this case, negative attitudes towards people with mental illness, developmental disabilities or addiction disorders.

SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) - A federal program to provide funds to states to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1year period.

SUPPORTS – Any of a large number of flexible activities or material resources intended to assist people to gain and maintain meaningful lives as citizens of their communities. See **NATURAL SUPPORTS, PAID SUPPORTS**

SUPPORT BROKER – A staff person who acts as an intermediary between the individual who needs supports and the agencies or programs that actually provide the supports.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires states to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from states that fail to comply with the SYNAR Amendment.

SYSTEM OF CARE (SOC) – A framework and structural approach to arranging the delivery and coordination of services for children and adolescents that employs evidence based thinking and arranges a comprehensive array of mental health and other services into a collaborative network to meet their multiple needs. The key principles of SOC are: the child and family are involved in the planning and delivery of treatment and services, services are coordinated and integrated, services are community-based in order to maintain the child in the family and in the

community, and the system must be culturally competent in order to be most responsive to the child's and family's needs.

SYSTEM PERFORMANCE - The extent that a system achieves its goals. The goals of the state mh/dd/sa system are found in the DMH/DD/SAS mission, vision and guiding principles.

SYSTEM PERFORMANCE MEASUREMENT - The process of assessing progress toward achieving state mh/dd/sa system goals and whether or not its principles have been applied and upheld.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available considering resources within the public system. See also, **PRIORITY POPULATIONS**.

TIMELY SERVICES - Access to services in a timeframe appropriate to their needs. Appointment with a physician within 72 hours of discharge from an acute psychiatric hospital unit is an example. See also, **PROMPT SERVICES.**

TRANSFORMATION – A deep, ongoing process along a continuum of innovation. Transformation implies profound change – not at the margins of the system, but at its very core. In transformation, new competencies develop.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

TREATMENT - The planned provision of services that are sensitive and responsive to a patient's age, disability, if any, gender and culture, and that are conducted under clinical supervision to assist the patient through the process of recovery.

TRIAGE - One name for a process by which people are assessed to determine the type of services and level of care they will require.

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM) - a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. UM is typically an externally imposed process based on clinically defined criteria.

UTILIZATION REVIEW (UR) - an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally imposed process that employs clinically established criteria.

VOLUME OF SERVICES – Method of representing the amount of services provided by a service provider.

WITHDRAWAL - A psychological and / or physical syndrome caused by the abruptly stopping or reducing substance use that has been heavy and prolonged. The symptoms include clinically significant distress or impairment in social, occupational or other important areas of functioning and are not due to a general medical condition or accounted for by another mental disorder.